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**THE MARKETING OF SMALL PROFESSIONAL SERVICE ENTERPRISES:**

**PHYSICIANS SERVICES IN PUERTO RICO**

Volume I of II

By

José M. Romaguera

**DURHAM UNIVERSITY BUSINESS SCHOOL**

Thesis submitted to the University of Durham  
in fulfillment of the requirements for  
the degree of  
Doctor of Philosophy  
2001

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THE MARKETING OF SMALL PROFESSIONAL SERVICE ENTERPRISES:  
PHYSICIANS SERVICES IN PUERTO RICO

ABSTRACT

This research utilizes the Model for Marketing in Small Professional Service Firms, based on Carson's Model for the Development of Small Firm Marketing, to examine the marketing of Physician Services in Puerto Rico. To achieve its objectives, a combination of quantitative (survey) and qualitative (cases) research is used.

From the literature a series of statements is generated to form hypotheses that are tested utilizing the results of a questionnaire survey of 105 physicians in Puerto Rico. The results suggest a possible change of attitude of service providers towards marketing and its use. They reveal that physicians in Puerto Rico are in agreement with the marketing concept but most do not adopt "traditional" techniques of marketing- preferring to focus on the physician/patient relationship.

Analysis of eight cases demonstrates the importance of this relationship and suggests that though is seen as important in attracting and retaining patients, most physicians do not see this as marketing, which is perceived to be mostly "advertising" and "selling." Many are cautious not to "commercialise" their practice and any differences in their behaviour can be explained by the way they believe the physician/patient relationship is best enhanced.

The research proposes a Model for Marketing Solo Professional Service Firms that depicts the relation between the changes, over time, in the personal life cycle of the service provider/owner-manager and the stages in the life cycle of the business practice. The model suggests that throughout there is a need to focus on one aspect of marketing for the practice, which may change over time, and that the elements determining the marketing activities at a particular time, how they are undertaken and why they are utilised, are constantly evolving. Thus the marketing practices of small professional firms appear to be contingent on both the external and internal environment of the practice.



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## CHAPTER 1

### INTRODUCTION AND OVERVIEW

#### 1.1 BACKGROUND TO THE STUDY

The service sector of the economy has grown considerably in post World War II years, accounting for more than half of the gross national product (GNP) in the western world (Grönroos, 1990). In the United States service jobs currently account for 79 percent of all jobs, and represent over 70 percent of the gross domestic product (Kotler, 2000). "Today more than 75 percent of all business and personal consumption in the United States goes to purchase services" (Dalrymple and Parsons, 2000, p. 338).

The deregulation in many countries in the 1980s of such service industries as communications, transportation and banking, as well as the entrance of product marketers into service industries (Kotler, 1994), has increased competition considerably in the service sector as the barriers that had shielded many of these industries from an increasingly competitive environment were removed. Fisk et al. (1993 pp. 70-71) describe the period as one where:

*"Firms in air transportation, financial services, health care, and telecommunications woke up to an environment of new rivals, intensified price competition, and rising consumer expectations. The role of marketing within these firms was transformed from being modestly important to being a core function vital to the survival of the organization. With most of these firms recognizing the greater significance of the discipline they were hungry to acquire and understand marketing knowledge. This need encouraged services managers and marketing academics to come together."*



According to Grönroos (1990), the transformation from manufacturing as the principal source of economic development to an economy based on service as the critical source of wealth has resulted in the need for a solid theory of service competition. In this context, the change from an economy dominated by manufacturing to one of continuous growth in the service sector has brought about a change of focus in marketing. Marketing evolved significantly in the second half of the twentieth century. From being considered mostly a function of large companies which mass produce goods and thus required mass selling efforts, marketing has begun to be regarded as an orientation towards understanding and meeting the needs of customers in goods as well as in service industries, in both larger and smaller enterprises (Kotler, 1994).

Within the area of services, the last 20 years have witnessed the emergence and development of a body of knowledge to address the particular differences of marketing services vis-a-vis products. The early literature (1960s and 1970s) focused on whether or not services marketing is an area that differs sufficiently from the marketing of goods to merit separate study. The literature (chapter 2) deals with the differentiation of services and goods and exposes the characteristics which make services marketing distinct from that of the marketing of goods. According to Berry and Parasuraman (1993) research on the marketing of services has been stimulated by the growth of the service sector, the deregulation in service industries, and the resultant increase in competition.

Within this framework, the area of professional services marketing has been stimulated by the removal of restrictions previously imposed on marketing practices, including advertising (Milliman and Fugate, 1993). The literature reviewed (chapter 2) shows that in the area of professional services the main research has been on the advertising aspect, resembling the emphasis on the "selling concept" (of manufactured goods) that dominated marketing after World War II (Kotler, 1994). This has been the case with research on professional services of architects (Stevens et al., 1993); lawyers (McCann et al., 1993; Milliman and Fugate, 1993); accountants (Traynor, 1983; Folland et al.,

1991; and Diamantopoulos et al., 1993); and physicians (Korgaonkar, 1985). The literature also shows research which compares attitudes among professional service providers towards advertising (i.e. physicians' and attorneys' - Stevens et al., 1990) as well as the attitudes of consumers toward the advertising of professional services by accountants, lawyers and physicians (Hite and Bellizzi, 1986).

Health care, clearly part of the service economy, is a major concern for developed as well as for developing countries. Advanced level economies view health care as a major priority as they are pressured to provide more and better health service to all citizens, while reducing the fiscal impact. Industrialized nations such as the United Kingdom, Japan, Germany, France and Canada provide universal health care at a cost representing from 6.1% to 9% of the Gross Domestic Product (GDP). By contrast, the United States in 1990 devoted 12.4 percent of its GDP to health care- the highest in the world, both as a share of the GDP and on a per capita basis (Organization for Economic Cooperation and Development et al., 1993). Notwithstanding this disproportionately higher spending, the United States in 1993 had a population of 37 million without health insurance, representing 14.7% of the population (significantly higher than in any other industrialised country), and an additional 25 million were without adequate coverage (Clinton, 1993). The situation is currently worst, as "the United States spends more on health care than any other country...(but) 44 million people across the country (is) without health insurance" and it is projected that "47 million people will have no insurance five years from now" (Consumer Reports, 2000 pp. 42-43).

Health care in Puerto Rico, a Commonwealth of the United States, is being impacted by the wide process of evaluation that is currently being undertaken in the United States, as well as by its own health reform programme. Both influences (the U.S. and the Puerto Rico initiatives) are designed with an emphasis on increasing health coverage in the population while keeping costs under check via the increase of built-in competition. This increase in competition amongst health care providers in

Puerto Rico makes health care an important sector and Puerto Rico an important region upon which to carry out the field work of this thesis.

The literature search suggests that the emphasis of marketing in the health services sector has been in the area of the larger organizations and the broader public health issues. However, the health care industry has not been excluded from the types of changes previously mentioned which have had a significant impact in other organizations, including an increase in competition (Kotler and Clarke, 1987). Further, the legal resolution of codes of professional ethics that banned direct client solicitation, advertising and price competition from the practice of professional services (including physician services) has had the result of allowing marketing for several professions. This, given the growth of competition in the sector, could tend to increase the use of marketing practices for physician services.

The literature argues that customers have accepted the use of marketing for professional services, though professional service providers appear to hold negative attitudes towards the use of marketing in their practice. The literature further suggests that service providers believe marketing is not necessary, particularly for small practises in the professions (Kotler 1994). In fact, most service providers researched after the elimination of the restrictions that banned marketing activities, equate marketing with advertising. Thus it appears that service providers have no clear understanding of marketing, believing that marketing is mostly advertising. This tends to support the notion that if the service provider disagrees with marketing, he/she will not use it for the practice.

Since most of the research about the attitudes of service providers towards marketing was done after the restrictions were banned, it could be argued that the respondents' answers were the result of having been schooled in, and by operating under, the belief that such activities were not appropriate.

Therefore, service providers new to the market place could have a different set of beliefs regarding the marketing of their practices.

The literature of small firm marketing is limited despite the significant impact of small businesses in the economy. More than half of the U.S. workforce is employed by small business, producing 75% of the GNP and creating 67% of all new jobs (Keats and Bracker, 1988). Birch (1979) reported that 80% of all new jobs are generated by firms with fewer than 100 employees and 66% are generated by firms with fewer than 20 employees. "The majority of jobs in the private sector are still generated by small firms" (Vikorean, 1991, p. 228). According to Carson (1993) the number of small firms in the United Kingdom grew by as much as 40% in the 1980s. Nevertheless, writing in 1985 Davis et al. (p. 32) said that "...scholarly research designed to improve our understanding of the marketing/small enterprise interface is nowhere to be found". This was confirmed more recently by Romano and Ratnatunga (1995) who examined 42 marketing-related studies on the small firm setting that appeared in six journals considered as representative of small business during the 1986-1992 period. They found that research concerning "the impact of marketing in the development of small enterprise... is extremely limited" (p. 111).

Small businesses have some different characteristics from those of large enterprises that deserve special attention. Schollhammer and Kurilof (1979) advanced five attributes of small businesses, namely: scope of operations (serving predominantly local/regional markets), scale of operations (limited share of a given market), ownership (equity owned by one or few people), independence (not part of another enterprise, owner/manager has ultimate authority and control), and management style (personalized, no general sharing of decision making). Similarly, Stasch and Ward (1987) argue that market and competitive circumstances are different for smaller businesses, that the owner's influence on management decisions is greater, and financial and organizational resources are limited. Davis, et

al. (1985, p. 32) further support the issue of differences as they compare the marketing practice for small and larger firms, namely:

1. “Small enterprises typically develop and implement marketing strategies within severe resource constraints”;
2. “Small firms typically lack specialized marketing expertise and often have difficulty in even trying to purchase this expertise”; and
3. “Small businesses often have different marketing objectives than larger business (leading to different strategies)”.

According to Brooksbank et al. (1992) the traditional marketing model (ie. formal long term planning, proactive perspective in planning, and aggressive marketing objectives and strategies) tends not to apply even in medium sized companies, as it has been developed for large organisations. In this context there has been an interest since the mid 1980s to understand the characteristics of small firms from a marketing perspective. Nevertheless, research to understand why small firms behave differently and how they evaluate, and make marketing decisions and how these are implemented and monitored was found to be lacking (Davis et al. 1985, Romano and Ratnatunga 1995).

## **1.2 DISCUSSION OF THE PROBLEM**

The problem, based on the literature reviewed (chapter 2), is that there is an absence of appropriate small business marketing theory in general, and the marketing of small professional service businesses in particular. According to the literature reviewed (Schollhammer and Kurilof, 1979; Stash and Ward, 1987; Davies et al., 1985; Romano and Ratnatunga, 1995; Siu and Kirby, 1998) there is a lack of research to understand why small firms behave differently from larger firms, how they evaluate and make marketing decisions, and how these are

implemented and monitored. For small professional service firms the lack of research in this direction is a problem, as competition in the service industry increases, since it is expected that the larger professional service enterprises will successfully evolve to a marketing orientation, a trend experienced in other industries as competition has increased. The smaller professional service firm that fails to embrace a marketing orientation is likely to be disadvantaged in the marketplace and may end up being in a reaction mode, compared with the larger professional service firms and their marketing actions. An early marketing orientation for the smaller professional service firm, which focuses on meeting customer needs, is therefore in the best interest of the service provider and of the customer. This apparent lack of understanding amongst service providers is best summarized by Kotler (1991 and 1994) who identifies the following three reasons why service firms do not use marketing:

- 1) many firms are too small to use formal marketing nor management skills;
- 2) other firms think that the use of marketing is not for professionals;
- 3) some firms think that the use of marketing is unnecessary.

As competition in the service sector continues to grow, the professional service providers, particularly the smaller enterprises, need "...to face (the) dramatic change in their environment..." (Lovelock, 1991 p. xi). Such dramatic changes place a tremendous burden on the service provider that owns and manages a practice, forcing him/her to consider actions that in turn impact on the internal environment of the practice. The perceptions and attitudes professional service providers in smaller enterprises have about marketing their practices are a key predictor of how they could undertake (or fail to undertake) marketing activities. It is important also to understand their decision-making process and how marketing activities are implemented and monitored in order to advance the knowledge of marketing of small professional service enterprises. The limited research on the marketing of professional services and the marketing of smaller enterprises makes this research one of particular significance.



### **1.3 PURPOSE OF THE STUDY**

The purpose of this study is to examine the roles that key components of the external and internal environment of the small professional service firm have in the process of adopting (or failing to adopt) a marketing orientation. The general framework to conduct the research, based on the literature reviewed (section 2.8) is the Model for Marketing in Small Professional Service Firms (figure 2.3) which incorporates both the external and internal environment into Carson's Model for the Development of Small Firm Marketing (1985, 1990, 1993) (figure 2.2).

The research examines the perceptions professional service providers in smaller enterprises have about marketing their private practices, what they understand marketing is, what they do and how this is done. The interest is in finding out what practitioners understand by the concept of marketing, what aspects of marketing they practise most, the extent to which they adopt a market orientation in order to gain insights into why they agree or disagree with the use of marketing for their practices, why they undertake (or fail to undertake) marketing activities and how they go about deciding, implementing and monitoring such activities.

The intention is to enhance understanding of both the theory and practice of the marketing of small professional service enterprises. The purpose, then, is for this research to further the body of knowledge through comparison with the literature and explain the findings and/or identify the limitation in the theory.

To facilitate this investigation, physician's services in Puerto Rico were taken as the case example. Chapter 4 offers an overview of the situation in the region/area where the field work for the research takes place.

The study specifically intends to:

- a) consider how physicians undertake marketing and the beliefs and attitudes they have about marketing their practices.
- b) determine the role of marketing in the physician's private practice.
- c) identify some of the relevant factors related to the attitudes of physicians towards the use of marketing in their practice.

The findings of the study are compared with the existing body of knowledge on professional services and small firm marketing in order to refute/corroborate the existing body of understanding and are used to evaluate the Model for Marketing in Small Professional Service Firms (figure 2.3) which is used as general framework for the research, and to propose changes, as needs be.

To achieve this the study requires the adoption of a research design and set of methodologies appropriate for the task in hand.

## **1.4 METHODOLOGY**

To meet the research objectives, the methodological design (chapter 3) consists of three phases, each utilizing the research methodology and instruments considered appropriate for the particular phase of work. Phase one includes a review of the literature (chapter 2) in an attempt to determine what is known in order to identify and provide the theoretical context for the investigation. This phase also includes an analysis of the area/region under study via secondary data (chapter 4) in order to understand the particulars of the area where the research was conducted and provide the situational context upon which to analyze the findings. The review of the literature provides the theoretical context for the investigation and helps formulate the general framework to conduct the research:

the Model for Marketing in Small Professional Service Firms (figure 2.3) which incorporates both the external and the internal environment into Carson's Model for the Development of Small Firm Marketing (1985, 1990, 1993). Based on the general framework for the research, and given the time and resources available, a combination of quantitative (section 3.4.3) and qualitative methods (section 3.4.4) were employed to carry out the investigation.

Phase two of the research design consists of quantitative research by means of a questionnaire (appendixes 1 and 2) administered to a sample of physicians in Puerto Rico. The translation of the questionnaire into Spanish was back translated to ensure the statements posed to the sample were comparable. The questionnaire includes classification data and allows respondents to self report by means of Likert type attitude scale (section 3.4.3.2) their level of agreement to forty one statements drawn from the literature, as explained in section 3.4.3.3. The objective of this phase of the research is to examine the level of agreement of the physicians with the statements drawn from the literature, and the use of marketing in their practice. The analysis includes testing a series of hypotheses (explained in sections 3.4.3.3 and 3.4.3.6) derived from the statements drawn from the literature, which include aspects dealing with both the external and the internal environment of the professional service practice (figure 2.3). With this quantitative research the degree of association between the physician's attitudes about marketing their practice and the variables under study (section 3.4.3.5) is determined. This phase of the research design helps to set the context for qualitative research based case studies (section 3.4.4) that constitute phase three.

Phase three of the research design is an attempt to clarify the concepts that emerged from both the literature review (phase one) and the analysis of the survey (phase two) and to further evaluate the Model for Marketing in Small Professional Service Firms (figure 2.3) utilised as the general framework for the research. The aim of this phase of the research is to examine

influences of key external and internal aspects of the small firm, over time, as it relates to the use (or lack of use) of marketing. The research also examines the interaction between the external and internal environment over the life cycle of the professional service practice. A qualitative technique (case studies, based on in-depth interviews with physicians in private practice) was used. A total of eight cases were conducted (section 3.4.4.3).

The analysis of these cases provides insights as to what physicians understand by marketing, why physicians agree or disagree with the use of marketing for their practice, why they undertake (or fail to undertake) marketing activities and how they go about deciding, implementing and monitoring such activities.

This research design provides for various mechanisms of triangulation: methodological triangulation (use of literature survey, quantitative and qualitative methods); data triangulation (use of secondary and primary data sources) and investigator triangulation (presenting preliminary findings of the results for feedback and evaluation from researchers in the field).

## **1.5 STRUCTURE OF THE THESIS**

The thesis is presented in seven chapters. Chapter 1 provides the background to the study and outlines the purpose and method of the research.

Chapter 2 reviews the literature and presents the key factors that have influenced the evolution of marketing- particularly in the areas of services marketing and marketing for smaller enterprises. Based on the findings from the literature review, as explained above, the areas to be studied are identified and the theoretical context for the investigation established. The chapter highlights the use of the life cycle models to describe the behaviour and development of firms over time and presents Carson's model for marketing in the small firm. The chapter explains the need to incorporate to the Carson model factors having to do with both the external and internal environment in order to

adequate it (based on the literature) to the small professional service firms. The resultant model for marketing in small professional service firms is used as the general framework to conduct the research.

In chapter 3 the purpose of the study and the methodology designed to meet the research objectives is presented. The aims and methodology for each of the three phases of the research is explained, including a series of hypotheses formulated for the research and the various statistical analysis for testing them. The formulation of each hypothesis is based on the literature review regarding the areas that need to be researched in order to understand more on the subject matter and thus be in a position to contribute to the existing body of knowledge.

An overview of health care and the state of the health care system in the United States and Puerto Rico at the time the research was undertaken is presented in chapter 4. The health reforms proposed and implemented, the impact these can have in shaping the new scenario under which physician's operate, and the implications for the marketing of physician services in solo practice are also presented.

Chapter 5 presents the results of the quantitative survey that examines a series of by hypotheses drawn from the literature, the level of agreement with the statements drawn from the literature and the use of marketing, and the degree to which physicians' attitudes towards marketing are associated with the variables under study.

The findings of the qualitative survey (case studies) are presented in chapter 6. These serve to clarify the concepts that emerged from both the literature review (chapter 2) and the analysis of the quantitative survey (chapter 5) and to further evaluate the model utilised as the general framework for the research. The chapter explains how the service provider (who is also the business owner in the

small professional service enterprise) goes about deciding, implementing and monitoring marketing strategies. The “why” of the findings are presented together with the resultant physician marketing system, as well as the physician’s patient referral system.

A summary of the research is presented in chapter 7. The chapter presents a summary of the findings and considers their implications for both theory and practice. Chapter 7 also includes an appreciation of the limitations of the research and presents recommendations for further investigation.

## **1.6 SUMMARY**

The service sector of the economy accounts for more than half of the gross national product in the western world (Grönroos, 1990). The deregulation of services industries in many countries in the 1980s increased competition considerably in the service sector as the barriers that had shielded many of those industries from a competitive environment were removed (Kotler, 2000).

Within this framework, the area of professional services marketing has been stimulated by the removal of restrictions previously imposed on advertising practices (Milligan and Fugate, 1993). Physicians’ practices in the region under investigation (Puerto Rico) were exposed to a series of significant changes. The changes included the removal of legal restrictions that prevented the use of certain marketing activities, and an increase in competition. The changes in the health industry, fueled by health reform initiatives, dramatically changed in a relatively short period of time the external environment upon which these services operate. Such dramatic changes in the external environment place a tremendous burden on the service provider that owns and manages a practice, forcing him/her to consider actions that in turn impact on the internal environment of the practice.

The insights gained from the research have significance for developments elsewhere as all economies aim to make better use of resources to provide universal care. The impact of the external and internal

environment in the smaller professional service practice, particularly as it is dramatically impacted by changes in the market place, is a particular contribution of the research that has relevance for similar developments taking place elsewhere in various service industries.

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## CHAPTER 2

### LITERATURE REVIEW

#### 2.1 INTRODUCTION

This Chapter provides a review of the key factors thought to influence the evolution of marketing. Particular emphasis is placed on services marketing, professional services marketing and marketing for smaller enterprises in an effort to determine what is known, in order to identify the areas to be studied for the subject under investigation and provide the theoretical context for the investigation.

#### 2.2 MARKETING

The literature shows that, through time, marketing has been described from very different perspectives. This is exemplified and summarised (Marketing Staff of the Ohio State University, 1965 p. 43) as follows:

*It has been described by one person or another as a business activity; as a group of related business activities; as a trade phenomenon; as a frame of mind; as a coordinative, investigative function in policy making; as a sense of business purpose; as an economic process; as a structure of institutions; as the process of exchanging or transferring ownership of products; as a process of concentration, equalization, and dispersion; as the creation of time, place, and possession utilities; as a process of demand and supply adjustment; and as many other things.*

The thrust of this reflects the fact that marketing traditionally has been described mostly as it relates to products, not to services. The simplification of marketing to four components (McCarthy, 1960) known as the 4 P's of marketing - product, price, place, and promotion - further dramatise this. The popularity of the 4 P's is reflected in the fact that it was used as a model upon which academic research and marketing textbooks of the decades to follow were based (Grönroos, 1993). This is further exemplified by Kent (1986, p. 146) as he refers to the 4 P's of the marketing mix as "the holy quadruple ... of the marketing faith ... written in tablets of stone".

To reflect the growth of the service sector, the "P" for Product was expanded to encompass "product/service" with the majority of the flavour and examples in the literature remaining mostly physical products rather than services; while others (Lambert and Harrington 1989; Collier, 1991) suggested "service" be added to the list of P's. In the area of service marketing three additional P's have been suggested: people, physical evidence and process (Booms and Bitner, 1982).

The 4 P's, along with the other basic aspects of marketing, remained as the core of the definition of marketing approved by the American Marketing Association in 1985, which states:

*Marketing is the process of planning and executing the conception, pricing, promotion, and distribution of goods, services, and ideas to create exchanges with target groups that satisfy customer and organizational objectives.*

This definition, still adopted by the American Marketing Association, has been described by Kotler (1994, p. 13) as a definition of marketing management since it recognizes that it is a process ("...involving analysis, planning, implementation and control...") covering goods,

services and ideas, resting on the notion of exchange with the goal of producing "... satisfaction for the parties involved."

That is not to say that there is universal agreement with the widely used 4 P's or with the possible inadequacy it has in fulfilling the marketing concept (ie. the notion that it is best for an organization to concentrate and direct its efforts to meet the needs of the customers it has chosen to target). This disagreement is best exemplified by Grönroos (1993 p. 4) when he states:

*"One can easily argue that the 4 P's of the marketing mix are badly fit to fulfill the requirements of the marketing concept. As Dixon and Blois (1983) put it "... indeed it would not be unfair to suggest that far from being concerned with a customer's interests (ie: somebody for whom something is done) the views implicit in the 4 P approach is that the customer is somebody to whom something is done!"...The marketing mix and its 4 P's constitute a production-oriented definition of marketing, and not a market-oriented or customer-oriented one...Moreover, although McCarthy (1960) recognizes the interactive nature of the P's, the model itself does not explicitly include any interactive elements. Furthermore, it does not indicate the nature and scope of such interactions."*

## **2.3 CUSTOMER ORIENTATION**

The evolution of the term marketing, as can be appreciated from the literature, has nevertheless focused more on the customer (vis-a-vis the product or the process of producing and selling). Kotler (2000, p. 17) refers to the Company orientations toward the marketplace as "...competing concepts under which organizations conduct (their) marketing activities." These

are the production concept, the product concept, the selling concept, the marketing concept, and the social concept. The difference between each has to do with the role, if any, that the customer plays in the process - how much his or her needs are taken into account in the process of designing and delivering products and services that meet those needs. Kotler (2000, p. 19) further defines the marketing concept as the one that "...holds that the key to achieving its organizational goals consists of the company being more effective than competitors in creating, delivering, and communicating customer value to its chosen target markets."

The more intense competition becomes, the greater the introspection required to determine what is needed in order to excel in the global marketplace. Peters and Waterman (1982) have advanced various "back to basics" findings of what makes the difference between excellent companies vis-a-vis their competitors. One of the "eight basic findings" of their research is that the excellent companies are "close to the customer". The thrust of their observation can be summarised by:

*"The good news from the excellent companies is the extent to which, and the intensity with which, the customers intrude into every nook and cranny of the business - sales, manufacturing, research, accounting. A simple message permeates the atmosphere. All business success rests on something labeled a sale, which at least momentarily weds company and customer. A simple summary of what our research uncovered on the customer attribute is this: the excellent companies **really are** close to their customers. That is it. Other companies talk about it; the excellent companies do it." (Peters and Watermann, 1982, p. 156).*

The notion of being close to the customer or indeed customer (market) oriented as necessary for success in the marketplace is the core of modern-day marketing which has indeed affected the

view of the business purpose of an entity as a whole. The most dramatic exposition of this (Levitt, 1983, p. 5-6) deals with the:

*"...genuine wisdom...about the special reasons why fairly free capitalist enterprises operating in relatively open markets vary in performance and about the characteristics associated with varying degrees of failure and success. That wisdom is, in fact, of relatively recent origin. Essentially it sets forth no more than the following few simple statements about the requisites of competitive success:*

- 1. The purpose of a business is to create and keep a customer.*
- 2. To do that you have to produce and deliver goods and services that people want and value at prices and under conditions that are reasonably attractive relative to those offered by others to a proportion of customers large enough to make those prices and conditions possible.*
- 3. To continue to do that, the enterprise must produce revenue in excess of costs in sufficient quantity and with sufficient regularity to attract and hold investors in the enterprise, and must keep at least abreast and sometimes ahead of competitive offerings.*
- 4. No enterprise, no matter how small, can do any of this by mere instinct or accident. It has to clarify its purposes, strategies, and plans, and the larger the enterprise the greater the necessity that these be clearly written down, clearly communicated, and frequently reviewed by the senior members of the enterprise.*
- 5. In all cases there must be an appropriate system of rewards, audits, and controls to assure that what's intended gets properly done and, when not, that it gets quickly rectified.*

*Not so long ago a lot of companies assumed something quite different about the purpose of a business. They said quite simply that the purpose is to make money. But that proved as vacuous as saying that the purpose of life is to eat. Eating is a requisite, not a purpose of life. Without eating, life stops. Profits are a requisite for business. Without profits, business stops."*

Levitt (1983, p.7) further states that "the most effective enterprises tend generally to practice (these concepts described above) most conscientiously".

It can be argued whether the purpose of a business is to create and keep customers, but the literature reviewed in this chapter does confirm the value of focusing on creating and keeping customers and suggests that it is the core principle of marketing (if not business) efforts. Indeed the thrust of most current literature concentrates on advancing ways to create and keep customers. This has resulted in the development of alternative theories of marketing, such as the Interaction/Network approach to the marketing of industrial goods which originated initially in the 1960s in Sweden (Blankenburg and Holm, 1990). This deals with the interactions that take place between the members of a network such as products/services, information, and financial exchanges.

## **2.4 SERVICES MARKETING**

Marketing in the twentieth century referred mostly to the marketing of physical goods. This was true even long after the emergence of a service dominated economy. As evidenced in the literature prior to the 1960s:



*"... the accepted wisdom that marketing meant goods marketing was rarely challenged. As the U.S. began the transition from an industrial to a services economy, the development received little notice in the marketing discipline. Although the national economy was dominated by services by the mid-1940s, some time elapsed before marketing scholars began to discuss and study the service economy and the services marketing that occurred within the economy" (Fisk et al. 1993, p. 66).*

Because of this, it is not surprising to find that the early (1960s and 1970s) literature on the matter focuses on whether or not services marketing is an area that differs sufficiently from the marketing of goods to merit separate study. The literature deals with the differentiation of services and goods, and exposes the characteristics which make services marketing distinct from the marketing of goods.

The debate on this issue was perhaps first posed by Johnson (1969) when he introduced the question of whether: "goods and services are different". Eight years later the debate was taken up in the first article published by the Journal of the Academy of Marketing Sciences on the subject of services marketing (Weinberger and Brown, 1977). In two articles entitled "Do we need service marketing?" and "Why we need service marketing," Bateson (1977 and 1979) advocated that new concepts were required for services marketing. This was the thrust of Thomas (1978) who argued that strategies traditionally developed for products were not appropriate for services, while Lovelock (1979) was most emphatic that the traditional concepts of marketing need to be broadened in order to include services marketing. With the publication of "Services Marketing is Different" (Berry, 1980) the debate as to whether services marketing merits separate study appeared settled and some (Shostack, 1977) even questioned if marketing

itself was being "myopic" in failing to develop guidance terminology and practical rules "relevant to services".

The differences between goods and services are summarised by Lovelock (1991 p.7) as seven "broad generic differences" which are "... generalisations that do not apply with equal force to all services". These are: nature of the product; greater involvement of customers in the production process; people as part of the product; greater difficulties in maintaining quality control standards; absence of inventories; relative importance of the time factor; and structure of distribution channels. These are further consolidated by Kotler (2000 p. 429) into "four major characteristics (of services) that greatly affect the design of marketing programs." These are intangibility, inseparability, variability, and perishability.

1. Intangibility: Berry (1980) described a good as "an object, a device, a thing" vis-a-vis a service which is "a deed, a performance, an effort." The basic difference has led to the theory advanced by Levitt (1981) that contrasts the need of the product marketer to add intangible elements to the offer of goods with the challenge of the service provider as one to "tangibilize the intangible."
2. Inseparability. This has to do with the fact that services are usually performed and used simultaneously. Customers are often actively involved and in some cases the provider is part of the service. Therefore either the customer, the provider or the interaction between them can have an impact on the service itself, the levels of expectations of the parties involved and the outcome. Relationship marketing (discussed later in section 2.4.4) has thus led to more

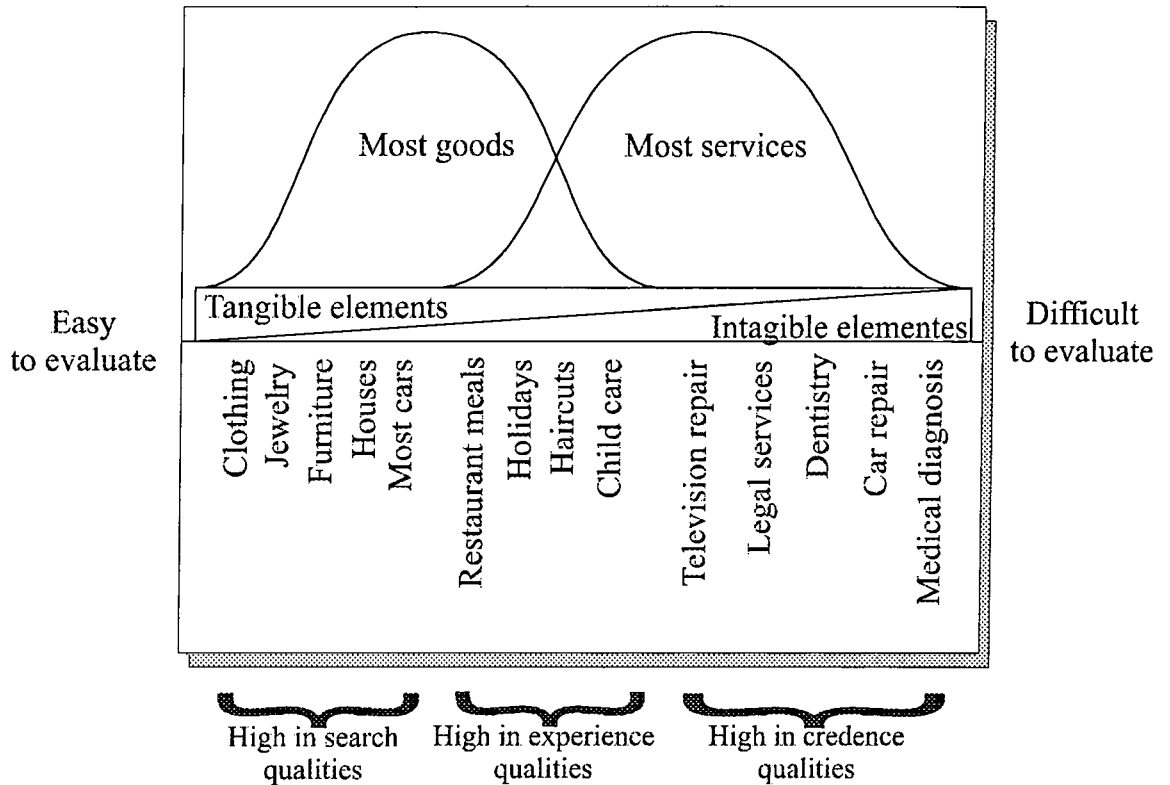
specific aspects of research in the services area as it focuses on the aspect of "service encounters". This will be discussed later (section 2.4.2).

3. Variability: Because of their dependence on who delivers the service and when it is provided, services can be highly variable. This has resulted in perhaps the largest area of services marketing research focusing on service quality. This area will be also discussed later (section 2.4.1) as it pertains to the monitoring of customer satisfaction, standardisation of the service delivery process and emphasis to obtain quality control.
4. Perishability: Services "per se" cannot be inventoried. This requires a concentrated effort to balance demand and supply in a service business (Sasser, 1976).

According to Zeithaml (1981), the combination of these four characteristics interact to form a continuum based on how easy/difficult it is for consumers to evaluate a physical product vis-a-vis a service (figure 2.1). Zeithaml establishes that services are more difficult to evaluate than goods. Services based on high credence qualities, particularly medical services, are the most difficult for consumers to evaluate even after consumption (Ostrom and Iacobucci, 1995).

Figure 2.1

Consumer Evaluation Continuum



The area of services marketing emerged during the 1970s, and in Scandinavia and Finland the Nordic School of Services suggested that the marketing of services is inseparable from overall management (Grönroos and Gummesson, 1985). The concept of the interactive marketing function was introduced by Grönroos (1979) "... to cover the marketing impact on the customer during the consumption process, where the customer of a service, typically to larger or smaller degrees interacts with various systems, physical resources and employees of the service provider" (Grönroos, 1993, p. 4). These interactions include those between the customer and part-time marketers (explained below) who in turn help in the marketing success of the firm.

According to Gummesson (1987) who coined the term "part-time" marketer, interactions are not limited to personnel from the marketing department, or to those person(s) formally assigned the role of overseeing marketing functions, so everyone in an organisation is, to a greater or lesser degree, impacting on marketing. Such "part-time" marketers generally outnumber the "full-time" marketers and formal "marketing and sales departments (the full-time marketers) are not able to handle more than a limited portion of the marketing as its staff cannot be at the right place at the right time with the right customer contacts" (Gummesson 1990, p. 13).

In fact, "the interaction and network approach of industrial marketing and modern service marketing approaches, especially the one by the Nordic School, clearly views marketing as an interactive process in the social context where *relationship building* is a vital cornerstone" (Grönroos 1993, p. 8). This relationship building has been referred to as "relationship management" by Levitt (1983 p. 111-126) in reference to consumer products, industrial goods as well as services:

*The relationship between a seller and a buyer seldom ends when the sale is made. In a great and increasing proportion of transactions, the relationship actually intensifies subsequent to the sale. This becomes the critical factor in the buyer's choice of the seller next time around. This is certainly true of all financial services, consultancy, general contracting, the military and space equipment industries, capital goods, and any vendor organization involving a continuous stream of transactions between seller and buyer (Levitt, 1983 p. 111).*

To further his point, Levitt (1983) refers to the evolution of "sales" as the "strategy" used in the past, giving way to "marketing" as the "present" strategy and projecting to "relationship" as the

"future" strategy, a fact he puts in perspective with the following illustration: *"The sale merely consummates the courtship. Then the marriage begins. How good the marriage is depends on how well the relationship is managed by the seller. That determines whether there will be continued or expanded business or troubles and divorce, and whether costs or profits increase"* (Levitt, 1983 p. 111).

During the late 1980s and early 1990s the relationship marketing concept emerged within the fields of service marketing and industrial marketing (Berry, 1983; Jackson, 1985; Grönroos, 1989a, 1989b, 1990a, 1990b; and Gummesson, 1987 and 1990). The focus of relationship marketing is the establishment and maintenance of relationships between customers and providers, as well as other parties in the marketplace, as a way of recruiting and retaining clients.

Relationship marketing has been supported by Kotler (1992, p. 1) who concludes that "companies must move from a short-term transaction-oriented goal to a long-term relationship-building goal". He further defines relationship marketing as "the task of creating strong customer loyalty" (Kotler, 2000 p. 49). Relationship marketing appears to be the underlying approach in several books on service marketing (Grönroos, 1990b; and Berry and Parasuraman, 1991), while others (Reichheld and Sasser, 1990; Sickle, 1993; Storbacka, 1993; and Reichheld, 1996) focus on the effects of poor practice in terms of lost customers. In the hospitality industry, for example, it is estimated that it is five times more expensive to attract a client vis-a-vis the cost of retaining one (Sickle, 1993). Other research has analysed the links between the relationships with customers and profitability (Storbacka, 1993). In services in general, it has been reported that by reducing customer defections by 5%, companies can improve profits from 25% to 85% (Reichheld and Sasser, 1990).

The growth of literature in the area of services marketing has evolved into specific focus areas which have been clustered (Fisk et. al., 1993) under five specific topics: service quality, service encounter/experiences; service design; customer retention and relationship marketing; and internal marketing. These will be discussed individually in the following sections.

#### **2.4.1 Service Quality**

This appears to be the area most researched in services marketing. The early literature in the area points to the conceptual work undertaken in Europe in the early 1980s as evidenced by Grönroos (1983), and the customer satisfaction theory (Oliver, 1980).

The team of Parasuraman, Berry and Zeithaml (1985, 1988, 1991a, 1991b) produced pioneering work on service quality which resulted in their GAPS model (1985), a well received conceptual framework, and SERVQUAL (1988), a measurement instrument for assessing perceptions of service quality. These have been used, with some modifications, by numerous researchers (Babakus and Boller, 1992; Bolton and Drew, 1991a, b; Brown and Swartz, 1989; and Carman, 1990) in their work and in the process they appear to have become the measurement instruments most used in the research on the area of service quality.

Service quality involves a comparison of customer expectations with customer perceptions of actual service performance (Grönroos, 1982; Parasuraman et al., 1985, 1988). According to Grönroos (1982) and Parasuraman et al. (1985) service quality depends on the outcome of the service and the process of service delivery.

Grönroos' (1983) model of service quality allows customers to perceive quality as a consequence of the correspondence between expectation of the services and the experiences of service production that the customer gets. Two types of quality concepts are defined:

- a. technical quality - what the customer receives, the end result of the service.
- b. functional quality - which refers to the production and delivery of services.

This model deals with the customer's perception of quality, the customer's expectations and experiences.

Gummesson (1988) indicates that the quality issue must be promoted by senior management as a starting point for the integration of quality over all the service-related areas. He describes a generic model of professional service in terms of eight parts that should be considered in a systematic service design: 1) specialist know-how, 2) personal characteristics of the professionals involved, 3) resources available and their attributes, 4) diagnosis of situation or problem and goal formulation, 5) the assignment in practice, 6) problem solution, 7) implementing solution, and 8) evaluation of resources.

Service quality has been demonstrated to be a predictor of value (Bolton and Drew, 1991) and is highly correlated with satisfaction (Brown and Swartz, 1989). Service quality is considered a key to competitiveness and profitability by what is referred to as the Nordic School of Services (Grönroos, 1984).

The interaction between customers and the service producer is a central factor in the attempts to define accurately the determinants of service quality (Berry et al., 1985; Minor, 1991). Many of these determinants revolve around personal interactions (Johansson, 1987), thus the need for



the quality assessment framework to focus on the individual employee, on the "servuction" system (physical, environmental, and organization structure), and on the service management system (Edvardsson and Gustavsson, 1990). Gummesson (1990a, p. 7) indicates that "service marketing theory has made quality a priority issue and has developed its own unique concepts and approaches." This is most important given that in the service industry, system-related quality defects account for 70% to 80% of quality problems (Edvardsson, 1990).

#### **2.4.2 Service Encounters/Experiences**

"The interface between the customer and the firm represents the service encounter" (Swartz, Bowen and Brown, 1992, p. 5). Research in this area concentrates on the interaction between service providers and customers or what has been referred to as "moments of truth" (Carlzon, 1990, Gummesson and Grönroos 1987, and Grönroos, 1990b). The roots of this line of research appear to be from 1985 (Czepiel, et al. and Solomon et al.). Research on this area focusses on the management of interactions (the management of customer and service provider interaction in the service encounter, based on trying to understand how customers evaluate service encounters); customer involvement (the customer's role in the process of the service being processed and delivered); and environment (the role of the physical environment and tangibles in the evaluation of service encounters by the customer).

#### **2.4.3 Service Design**

As mentioned previously (section 2.4), variability is one of the major characteristics of services (Kotler, 2000). To overcome this situation, attention has been paid to the planning and delivery of the service process. The contribution in the literature on this matter appears to be centred on service blueprinting and service mapping which incorporates the customer, and his/her actions,

in the service delivery process, while the design of the service operation is seen from the customer's perspective. Research on this area is based on the work of Shostack (1984, 1987, and 1992) and Kigman-Brundage (1989, 1992).

#### **2.4.4 Customer Retention and Relationship Marketing**

"Relationship marketing recognizes the value of current customers and the need to provide continuing services to existing customers so that they will remain loyal" (Fisk, Brown and Bitner, 1993, p. 81). Anderson and Vincze (2000, p. 262) argue that "the inseparability, at some level, of the service provider and customer should lead to a relationship of mutual trust."

Berry (1983) was one of the first to introduce the importance of keeping and improving relationships with existing customers. Others have expanded the concept of relationship marketing noting, among other things, that different types of relationships are appropriate for different types of customers (Jackson 1985); relationships are not a substitute for having a strong up-to-date core service (Crosby and Stephens 1987); that success revolves around strong relationships (Grönroos, 1990a; Schlesinger and Heskett, 1991); and that "relationships between service organizations and customers are often close and long-lasting" (Dalrymple and Parsons, 2000, p. 347).

The need to attract and retain customers, as previously explained, has become a focus of research in the services area (e.g. Grönroos, 1990a and 1990b). Some have focussed on the cost of losing customers (Reichheld, 1996; Reichheld and Sasser, 1990) while others have focussed on strategies for retaining customers, including recovery strategies when service failure occurs (Berry and Parasuraman, 1991; Hart, Sasser and Heskett, 1990) and trust and relationship

commitment and how they relate to customer satisfaction and loyalty (Crosby and Stephens, 1987; Crosby, Evans and Cowles, 1990).

#### **2.4.5 Internal Marketing**

This is based on the premise that satisfied employees (who can be viewed as "part-time marketers") are more likely to better deal with those customers with which they come in contact and this will have an impact on customer satisfaction. Based on this premise, researchers (Hauser et al., 1996; Greene et al., 1994; Berry and Parasuraman, 1991; Grönroos, 1990a and 1990b; and Gummesson, 1987) argue that there is a need to focus on marketing to the employees of the company - internal marketing - as a way to serve the final customer. Kotler 2000 (p.435) describes internal marketing as "the work to train and motivate employees to serve customers well".

Two principal ideas underly the concept of internal marketing. First, "everyone in the organization has a customer" (Grönroos, 1981). Second, that internal customers must be "sold" on the service and should be happy in their jobs before they can effectively serve the final customer. For this reason, Berry (1986 and 1981) explains that internal marketing encompasses the use of marketing tools and orientation to attract, motivate and keep the best employees.

Internal marketing is viewed as a powerful tool for improving service quality and for developing a service quality culture (Lehtinen and Laitamaki, 1985). The literature on services marketing and organisational culture suggests that an appropriate culture or climate is one of the most important ingredients for successfully marketing services (Pascale, 1984). Organisational culture refers to the pattern of shared values and beliefs that help individuals understand organisational functioning and thus provides them with norms for behaviour in the

organisation (Deshpande, Rohit and Webster, 1989). The organisational culture of a firm affects the firm's ability to meet its needs and demands, the employee's behaviour and satisfaction and, also, the way the firm copes with the external environment. It establishes the rationale for appropriate and inappropriate behaviour (Amsa, 1986). The marketing culture of a service firm refers to the way marketing "things" are done in the firm. Indeed, according to the work of Webster (1991) there is a relevant relationship between the type of marketing culture a service firm has and its profitability and marketing effectiveness.

## **2.5 PROFESSIONAL SERVICES MARKETING**

The combination of a more competitive marketplace, the focus on the customer in order to create and keep clients, together with the longer term approach of relationship building by all in the organisation (including part-time marketers) sets the stage for the marketing of professional services.

It has been predicted (Kotler and Bloom, 1984) that more intense competition is to be expected in various professions given the increase of certain professionals as well as the oversupply of professional services provided by "paraprofessionals".

Publications relating to the marketing of various professional services began to proliferate in the 1970s. These include architectural and engineering services (Weld, 1971), accounting services (Mahon, 1978) and legal practices, (Gilson et al. 1979); followed by works on the marketing of professional services in general (Brown, 1989; Webb, 1983; and Wheatley, 1983).

Professional services marketing can be defined as follows (Kotler and Connor 1977, p. 72):

*"Professional services marketing consists of organized activities and programs by professional services firms that are designed to retain present clients and attract new clients by sensing, serving and satisfying their needs through delivery of appropriate services on a paid basis in a manner consistent with creditable professional goals and norms."*

There appears to be consensus that service quality is one of the most important problems facing management (Blackiston 1988; Cound 1988; Cravens 1988; Langevin 1988; Sherden 1988). As discussed earlier (section 2.4.1), service quality appears to be the area most researched in services marketing. Similarly, service quality is important to the success of professional practices. The role of marketing in communicating quality for professional services is clearly illustrated by Gummesson (1979, p. 9) who comments that "the quality of a professional service becomes a matter of a subjectively perceived quality ...also influenced by the professional's ability to sell himself and to sell his results", that the client is "buying confidence." According to Bleidt (1988) being the best provider per se do not necessarily translate into attracting the most patients, as service providers must be able to communicate the quality of their services if they are to compete. In this context, the literature suggests that the service provider needs to communicate quality from the perspective of the needs of the customer.

The customer orientation which is core to marketing (section 2.3) has to be the focus in service firms, including professional services (Kotler and Bloom, 1984; and Kotler 1994, 2000). Parasuraman, Berry and Zeithaml, (1983, p. 28) summarise this best: "service firms, regardless of their industry, size, geographic scope, primary customer groups, or competitive situation, can and should conduct their business on the basis of satisfying customer needs."

Some of the most critical problems for professional service firms are the implementation of the marketing strategy and the professional culture that exists in their organisations. According to Morgan (1990a, 1990b) the professions face mostly internal marketing problems related to market orientation and strategy implementation issues rather than problems concerned with external communications. Morgan (1990a, 1990b) further explains that the tendency of professional firms to organise around technical service excellence and not around clients and their needs, can make it difficult for these practices to develop a marketing orientation.

According to Crane (1993) to compete effectively firms need to balance “high-tech” and “high-touch” and must stress relationship marketing (sections 2.4 and 2.4.4) in order to ensure growth. This is particularly important as competition increases and professional service providers confront a series of marketing challenges (ie. selection of marketing strategies and tactics and how to organise for marketing) (Bloom, 1984).

The forces of de-regulation and increasing competition in the last two decades have combined to form a tremendous pressure for professional service firms of all types to consider the role that marketing may play in the management and strategic direction of their business (Piercy and Morgan 1989a, 1989b). The previous restrictions on advertising and other marketing activities for professional service providers limited the development of marketing of these practices for over fifty years. According to Milliman and Fugate (1993) restrictive advertising practices for professional service providers was the norm of most professions in the U.S. between 1922 and 1977. The reason for this was "...the premise that commercial speech did not enjoy First Amendment protection (and) as such, freedom to advertise could be (and routinely was) bridged by local, state, and association authorities" (Milliman and Fugate, 1993, p. 53). This changed with the result of the *Bates vs. State Bar of Arizona* case (1977) when the U.S. Supreme Court decided in favour of Mr. Bates under the right to free speech (the First Amendment) and the

Fourteenth Amendment, that a citizen cannot be deprived by a state of rights he has been granted under the First Amendment (Ostlund, 1978).

The Federal Trade Commission brought legal action against the American Dental Association during the same period, "... claiming that its ban on advertising of fixed prices for services prevented dentists from seeking new patients" (Traynor, 1983, p. 36). The Federal Trade Commission was also successful against the American Medical Association's ban on advertising which allegedly prevented competition. Similarly, in 1978, "... as a result of the pressure by the Federal Trade Commission, the American Institute of Certified Public Accountants amended its code of professional ethics to allow advertising" (Traynor 1983, p. 36).

The arguments for and against the advertising of professional services include both philosophic and economic dimensions (McCann, Stem, and Muehling, 1993). According to the literature (Bates v. State Bar of Arizona 1977; Burton and Dorrough 1988; Darling and Bergiel, 1983; Dyer and Shimp, 1989; Linenberger and Murdock, 1982; Ryder 1985, and Shimp and Dyer, 1978), the debate regarding the pros and cons of advertising professional services centres around the following issues: (1) the impact of advertising on consumer demand; (2) the impact of advertising as a barrier to market entry and as an advantage for the larger providers that can afford bigger advertising budgets; (3) the impact of advertising on employment opportunities for professionals; (4) the impact of advertising on prices charged to consumers; (5) the impact of advertising on service quality; (6) the impact of advertising on consumer awareness of service needs; (7) the impact of advertising as an aid to consumers in choosing service providers; and (8) the impact of advertising on consumer expectations, leading to ultimate consumer dissatisfaction.

The debate for and against the advertising of professional services gave way to research about the perceptions of both service providers and consumers towards advertising. Many research studies indicate that consumers have positive attitudes toward their perceptions that professional service advertising provides useful information (Bush and Moncrief, 1985; Hite and Kiser, 1985; Hite and Fraser, 1988). However, other studies argue that the attitudes and opinions of service providers towards advertising their practice are negative (McCann, Stem and Muehling, 1993; Stevens, McConkey and Loudon, 1990; Hite and Fraser, 1988; Miller and Waller, 1979; Darling and Hackett, 1978).

Other research has focused on comparisons of the use of advertising by different professional service providers. Traynor (1983), for example, reports that accountants advertise at twice the rate of attorneys. He further comments: "the apparent acceptance of advertising by certified public accountants could represent a precursor of similar acceptance by other professional groups". Notwithstanding Traynor's forecasts, accountants appear to undertake relatively minimal advertising (Watkins and Wright, 1986) and some studies have demonstrated that accountants regard advertising as a relatively unimportant promotional tool (Traynor, 1984; Diamantopoulos et al., 1989 a, b.; Bussom and Darling 1978). Diamantopoulos et al. (1989 a), have further argued that the availability of financial resources has a significant influence on the advertising practices of accountancy firms, advertising practices, whereby the big firms are more likely to advertise, to use advertising agencies and, also, to be more systematic in their approach to advertising. The issue of practice size is presented in section 2.7 (marketing of small enterprises).



## 2.6 Health Services Marketing

Within the general field of services marketing, considerable attention has been paid in recent years to the specific area of health services marketing. The field ranges from the marketing of hospitals to ambulatory services and mental health and the literature yields various examples of public health and health educational issues in which marketing and advertising have played a role. These include public health aspects of beverage marketing (Rosovsky, 1985; Cowan, and Mosher, 1985; Mc Bride, 1985), the use of television advertising to reduce alcohol consumption (Barber, et al., 1989), and sales of cigarettes and anti-smoking campaigns (Bishop, and Yoo, 1988; Kao, and Tremblay, 1988;). Issues such as abortion, anti-abortion and family planning have also seen a marketing involvement (Bertrand, et al., 1987). Recent examples of the use of marketing by large hospitals includes their opening of clinics in other locations to benefit from the reputation of their excellence in a given area of medical expertise. This is best illustrated by Kotler 2000 (p. 438): "several hospitals have attained "megabrand" reputations for being the best in their field, such as the Mayo Clinic, Massachusetts General and Sloane-Kettering. These hospitals could open clinics in other cities and attract patients on the strength of their brand reputation."

The aspect of ethics and marketing/advertising in the context of health care and marketing appear to remain a major issue despite the removal of the objection to advertising over a decade ago. This can be observed in the literature relating to medical ethics, advertising, and the physician/patient interface (Nelson, et al., 1989; Colman, 1989; Mc Carthy, 1989). The issue of the physician/patient relationship appears to have been brought into focus by the issues of confidentiality in terms of ethics and of confidential communication in general (Emson, 1988; Weiss, et al., 1986; Warwick, 1989) and with regard to the aspects of breach of confidentiality among individuals with the AIDS virus (Schwartzbaum, et al., 1990) in particular. The

literature suggests that the emphasis of marketing in the health services sector has been in the area of the larger organisations and the broader public health issues. The health care industry has not been excluded from the types of changes previously mentioned which have had a significant impact in other organisations, including an increase in competition. As Kotler and Clarke (1987, p. 3) have observed:

*“A great variety of health care organizations are facing marketing problems... (and)...are confronting a multitude of changing variables in the marketplace: increased regulation, decreased outside funding, more aggressive competition, drastically changing reimbursement policies, a growing shortage of certain necessary clinical skills and an oversupply of others, a wave of entrepreneurial ventures by both health care providers and nonproviders, and a more critical consumer or patient population ... managers of health care organizations ... are being forced to see what marketing might offer to keep their organizations viable and able to respond to future challenges. At the same time, many health care managers are approaching the marketing function with caution. Although most health care organizations have readily accepted ... (other) business functions ... some have been skeptical about marketing. Marketing connotes "big business" - commercialism and Madison Avenue gimmickry - particularly to those with little actual exposure to the marketing function. In addition, marketing appears to conflict directly with the antisolicitation rules contained in the professional ethics of most clinical professions”.*

Services marketing, as mentioned earlier (section 2.4), has various characteristics that differentiate it from the marketing of physical products. Following that line, Kotler and Clarke (1987, pp. 12-13) have proposed "the distinctive characteristics of marketing in health care organizations ... whether profit-oriented or not..." which includes the fact that:

*"Most health care organizations are engaged in the production of services rather than goods. Services are intangible, inseparable, variable, and perishable. A medical group practice offers an intangible service called health care; its delivery is inseparable from its deliverers (physicians, nurse-practitioners); its quality is variable with respect to who delivers it; and it is perishable in that an empty nurse-practitioner's office or idle physician means a loss of the associated revenue, since a service cannot be stored. Service marketers must keep these characteristics in mind when developing marketing strategies and plans. Moreover, production and consumption of the service occur simultaneously, so the consumer must be integrated into the production process".*

This characteristic has a bearing on both the large and the smaller health service organisations - including solo physician practices and is very much in line with the various specific focus areas upon which service marketing, in general, has evolved (Fisk, et. al, 1993), namely: service quality; service encounter/experiences; service design; customer retention and relationship marketing; and internal marketing.

The area of health services marketing has lagged somewhat behind services marketing. The reasons for this can be summarized by the fact that marketing was " ...an unaccepted concept in health care management until the early 1980's" (Kotler and Clarke, 1987, p. 24). However, Nelson and Goldstein (1989, p. 87) comment that *"quality of health care will become a major*

*marketing issue in the decade ahead. Much of the thrust is because the industry is dealing with increasingly sophisticated consumers, employees, government agencies and other buyers of health services. With heightened awareness of quality issues, these groups seek ways to define and measure quality and will make decisions about where to obtain health care based on objective evidence and perceptions of service quality."*

Health care management has struggled with the issue of marketing, clearly focusing on the larger health institution as exemplified by:

*"Is it acceptable for a health institution to expend community resources to increase its power, dominance or influence by increasing the inpatient census when that may cause another institution to decline? Many influential people in the field feel quite strongly that hospitals should not use precious resources to devour each other. They feel that there is little room for divisive competitive promotion today." (Garton, 1979, p. 65).*

For the practice of professional services, including physician services, the codes of professional ethics proscribed direct client solicitation, advertising, and price competition. This was legally resolved in the United States in the late 1970s early 1980s as *"...the Supreme Court held that these bans in codes of professional ethics had the effect of reducing competition through depriving organizations of the right to inform potential clients about their services and depriving potential clients of useful information about the organizations. As a result, advertising and certain other marketing practices have now been allowed in several professions"* (Kotler and Clarke, 1987, p. 21).

Many studies (Miller and Waller, 1979; Darling and Hackett, 1978; Hite and Fraser, 1988) have revealed that the majority of physicians still hold a negative attitude toward advertising their professional practices in contrast to consumers who were found to have a positive attitude towards the advertising of professional services. The negative attitude of physicians toward medical advertising is compounded by the fact that throughout the medical profession, there is a poor understanding of the basic principles of marketing with the majority equating it to advertising (Korgaonkar, 1985).

An area of where both physicians and patients share a common interest is found in the literature as “patient satisfaction”. A variety of variables have been employed to measure consumer satisfaction levels in health services entities. The variables utilized by Hulka et al. (1975) for example, include communication and measurement of patients’ attitudes towards the system. Bertakis (1977) and Ley (1983) on the other hand have suggested that patient satisfaction appears to be linked to the information provided by the physician. Kaim-Caudle and Marsh (1975) focused on the tangible to measure satisfaction, namely practice premises, receptionists and the appointment system, while Woolley et al. (1978) included satisfaction with outcome and continuity of care among the dimensions utilised to measure patient satisfaction. The Physician/patient relationship was utilized by Feletti et al. (1986), and by Wolf et al. (1978) in their research for measuring patient satisfaction. The variety of variables upon which patient satisfaction is measured, appears to suggest that the marketing efforts of physicians needs to cover a wide range of aspects to achieve client satisfaction.

## **2.7     MARKETING OF SMALL ENTERPRISES**

More than half of the U.S. workforce is employed by small businesses, producing 75% of the GNP and creating 67% all new jobs (Keats and Bracker, 1988). Birch (1979) reported that

80% of all new jobs are generated by firms with fewer than 100 employees and 66% are generated by firms with fewer than 20 employees. "The majority of the jobs in the private sector are still generated by small firms" (Vikorean, 1991 p. 228). According to Carson (1993) the number of small firms in the United Kingdom grew by as much as 40% in the 1980s. Nevertheless, "...scholarly research designed to improve our understanding of the marketing/small enterprise interface is nowhere to be found" (Davis et al. 1985, p. 32). This was confirmed more recently by Romano and Ratnatunga (1995) who examined 42 marketing-related studies in the small firm setting that appeared in six journals considered as representative of small business research during the 1996-1992 period and found that research concerning "the impact of marketing in the development of small enterprise...is extremely limited" (p. 111). More recently Siu and Kirby (1998, p. 55) confirmed the "...need to understand... why small firms behave as they do and how they make their marketing decisions and choice."

Small businesses have some different characteristics from those of large enterprises that deserve special attention. Schollhammer and Kurilof (1979) advanced five attributes of small businesses, namely: 1- scope of operations (serving predominantly local/regional markets), 2- scale of operations (limited share of a given market), 3- ownership (equity owned by one or few people), 4- independence (not part of another enterprise, owner/manager has ultimate authority and control), and 5- management style (personalized, no general sharing of decision making). Similarly, Stasch and Ward (1987) argue that market and competitive circumstances are different for smaller businesses, that the owner's influence on management decisions is greater, and financial and organisational resources are limited. Davis, et al. (1985, p. 32) further support the issue of differences as they compare the marketing practice for small and larger firms, as namely:

1. "Small enterprises typically develop and implement marketing strategies within severe resource constraints";
2. "Small firms typically lack specialized marketing expertise and often have difficulty in even trying to purchase this expertise"; and
3. "Small businesses often have different marketing objectives than larger business (leading to different strategies)".

According to Brooksbank et al. (1992) the traditional marketing model (ie. formal long term planning, proactive perspective in planning, and aggressive marketing objectives and strategies) does not apply even in medium sized companies, as it has been developed for large organisations. In this context, there has been an interest since the mid 1980s in understanding the characteristics of small firms from a marketing perspective.

The literature advances a series of particular marketing recommendations for small businesses following the mix of the 4 P's (section 2.2). Roger (1990), for example, advances the desirability of small firms to consider a penetration pricing strategy, pre-emptive pricing strategy, as well as high price and low price policies among its marketing options. Davis et al. (1985), on the other hand, propose that small firms are more likely to succeed when price is not the primary strategic element, the price can be negotiated, or the prices are set within a comfortable profit margin. In this context, Pinson and Jinnette (1993) argue that small companies that focus on lower prices have less probability of survival and success than small firms that emphasise customer satisfaction.

According to McAuley and Rosa (1993) marketing in the small and medium high growth firm begins and ends with the customer. This is in agreement with the overall perspective of marketing as being a customer orientated activity for all types of enterprises (section 2.3). La

Barbera and Rosenberg (1989) propose that for smaller firms, however, the possibility of being closer to the customer represents a superiority which can be turned into a competitive advantage. This is supported by Roger (1990) who argues that since small firms concentrate operations locally they deal directly with the final customer, having greater control over the selling process. On a macro level, Vikorean (1991 p. 227) concludes that *"it is suggested that the sustainment of the small firm sector may be attributed to their marketing orientation (...) that the customer orientation is, in fact, a sustainable comparative small scale advantage."*

The desirability of smaller firms focusing on being customer oriented suggests that the relationship marketing concept (sections 2.4 and 2.4.2) could be particularly appropriate for smaller enterprises. It can be argued that relationship marketing is particularly important in the small firm operating in the service sector, given that in services the customer is involved in the service delivery process as a "co-producer" (Edvardsson and Mattsson 1993), and the interaction between the customer and the service producer is a central factor in the attempts to define accurately the determinants of service quality (Edvardsson et al. 1989).

Notwithstanding the importance of the small business sector of the economy and the particular characteristics of small firm marketing mentioned earlier, knowledge about marketing in small business remains inadequate and incomplete (Davis and Klassen, 1991). Research initiatives on the subject of small firm marketing have included a review of the literature to inventory and catalogue previous research efforts. Romano and Ratnatunga (1995) utilized the Webster (1992) classification system and cataloged marketing research thrusts within small enterprises in three major areas, mainly marketing as a culture, marketing as a strategy and marketing as tactics. The research found each of these thrusts had approximately an equal number of articles and that survey techniques was the methodology most utilised.



According to the literature (Hills, 1987; Wortman, 1987; Hisrich, 1989) there is an absence of appropriate small business marketing theory, particularly related to the understanding and knowledge of strategic marketing. Actions undertaken to foster appropriate research in the area includes the Research Symposia on the Marketing/Entrepreneurship Interface which have been conducted annually for the last decade in several continents, reflecting the international attention the subject has received.

Siu and Kirby (1998) identify from the literature the stage/growth model as one of the four approaches to marketing in small enterprise research, and advance that:

*“Due to the specific limitations and constraints of small firms, the marketing behaviour of small firms will be different from that of larger firms, and not necessarily follow the prescription of the normative marketing approach. Thus, there is a need to understand (...) why small firms behave as they do and how they make their marketing decisions and choice.” (Siu and Kirby, 1998, p. 55)*

As explained in chapter 3, this research aims to understand why small professional service firms behave as they do in terms of marketing their practice, how they decide, implement and monitor marketing activities utilising a case study of physicians in small practices in Puerto Rico. To do this the small firm marketing model developed by Carson (1985, 1990, 1993) has been adapted to include key characteristics of small professional service practices found in the literature. This model is explained in section 2.8.

## **2.8 MARKETING AND THE SMALL FIRM LIFE CYCLE MODEL**

### **2.8.1 Introduction**

As explained in section 2.7, there is an absence of appropriate small business marketing theory. The literature review (section 2.8.2, below) highlights the use of the life cycle models (also referred to as developmental stages, stages model, growth model, or stage/growth model) to describe the behaviour and development of firms over time. Utilizing these types of models, Carson (1985, 1990, 1993) has proposed a model specifically for the evolution/stages of marketing development in small firms. This section provides an overview of the life cycle model (section 2.8.2) as well as a description of the Carson model for marketing in the small firm (section 2.8.3). Key characteristics of small professional service firms found in the literature regarding the external (section 2.8.4) and internal (section 2.8.5) environments are included in order to show how these fit into a proposed model for marketing in small professional service firms (section 2.8.6). The resultant model serves as the general framework to conduct this research.

### **2.8.2 Overview of the Life Cycle Model**

The life cycle analogy has been used to describe the behaviour of firms, namely to explain the development of organisations over time (Hanks, 1990). Organizational theorists (Hanks et al. 1993, Kazanjian and Darzin, 1989; Miller and Friesen, 1983; Quinn and Cameron, 1983; and Kimberly et al. 1980) have suggested that organisations pass through a series of predictable and necessary life cycles or stages, similar to the cycle of organisms. The life cycle concept, as applied to firms, has resulted in models where organisations are born, grow, mature, decline and die (Adizes, 1988; Chadler, 1962; Child and Kieser, 1981; Dodge and Robbins, 1992;

Downs, 1966; Quinn and Cameron, 1983; Greiner, 1972, Kimberly and Miles, 1980; Lippitt and Schmidt, 1967; and Miller and Friesen, 1983).

The particular number of stages an enterprise passes through varies from model to model, from as many as ten stages (Adizes, 1991) to as few as three (Smith et al., 1985). Most authors, however, consider a four (Kazanjian, 1988 and Quinn and Cameron, 1983) or a five stage model as appropriate (Scott and Bruce, 1987; Miller and Friesen, 1984; Churchill and Lewis, 1983; Galbraith, 1982; and Greiner, 1972). Notwithstanding the wide variance in the specific number of stages, the "models suggest a fairly consistent pattern of organization growth..." (Ferreira 2000, p. 6). The variety of models of organisational life cycle mentioned above, is reflective of the use of these type of models to research enterprises as a means to understand their behaviour over the stages they encounter. Despite criticism of the concept, life cycle models continue to be used to study enterprises, including small firms, in a variety of countries as well as through out different industries. Recent examples include a four stage model of organisational life cycle in the New Zealand wine industry (Beverland, 2000), a study based on stage configurations of the life-cycle applied to small and medium enterprises in the manufacturing industry of the Beira Interior region of Portugal (Ferreira, 2000), a study of leading growth oriented firms in Ontario, Canada (Rumball, 2000), a longitudinal study of owner-managers of firms from all industry sectors in Australia (Mazzarol, 1999), industrial SMEs in Finland (Halttunen, 1999), and small firms in the business of automobile ancillaries in India (Mitra and Pingali, 1999).

### **2.8.3 The Carson Model for Marketing in Small Firms**

The literature review (section 2.8.2) indicated that although life cycle models have been fairly utilised in researching the behaviour and development of firms over time, there is very limited

use of a life cycle model specifically to investigate the development of marketing in small firms. This exemplifies the absence of appropriate small business marketing theory explained in section 2.7. The review of the literature (Carson 1985, 1990, 1993; Fuller 1994) further points out that the Carson model for marketing in small firms (explained further below) is most appropriate for this research, given its uniqueness and particular relevance to the study. The main reason is that the Carson Model is the result of a continuous, on going, research effort. It is underpinned by previous research. For example Tyebsee et al., 1983, proposed a four stage evolutionary process of marketing for growing firms. The original Carson model of 1985 is based on a study of the small business economy in Northern Ireland. Carson followed his research with a longitudinal study (1990) that further refined the model. Throughout the years Carson has continued to utilise the basics of his model for considering implications to the marketing discipline, such as proposing new approaches to marketing education in small firms (1993), challenging existing marketing theory by focusing on marketing competencies (Carson and Gilmore, 2000), and in networking as a way to develop small firms (Gilmore and Carson, 2000).

Further reasons why the Carson model is appropriate for this research include the fact that it has been reviewed by others. Robins (1991), for example, has commented on the need to further refine the categories utilised by Carson, and Fuller (1994) has utilised the model for his research and confirmed the model's validity. Fuller (1994, p. 48) further suggests that the Carson Model "...might be useful to those working with small and medium sized businesses, including educators, trainers, consultants and lending agencies...". All of this is of interest given the objective of this research to further the theory and practice of marketing in small professional service firms.

The Carson model, however, has its limitations. The model fails to incorporate explicitly the context upon which the firm operates, namely the internal and the external environments, as well as the interactions of the owner/manager with these and the resultant impact such interactions may have in the marketing of small firms. The external environment issues (sections 2.8.4) as well as the internal environment issues (section 2.8.5) are incorporated to the Carson model in order to overcome these limitations. The resultant model (section 2.8.6) is used as the general framework for the research.

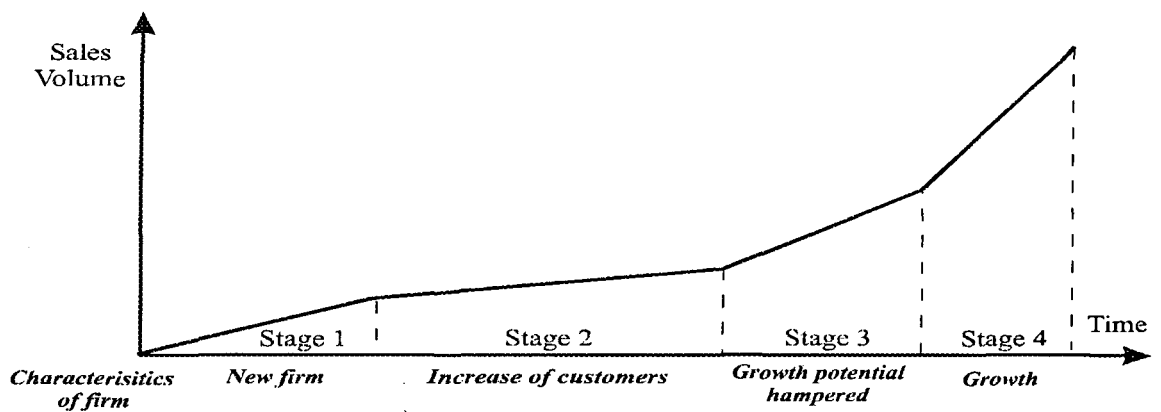
Carson (1985) first proposed a model of the development of small firm marketing based on four stages of marketing evolution, namely: initial marketing activity; reactive selling; the DIY (do it yourself) marketing approach; and integrated proactive marketing. Carson argues that initial marketing activities are mostly based on personal contacts with practically no promotional support, minimal selling activity, and word of mouth recommendation. As the customer base increases marketing activity is reactive to enquiry and demand with brochures and promotional letters as some of the marketing tools utilised. The potential for growth is then hampered by the small firm's lack of resources to employ 'expert' assistance which forces the owner to the DIY marketing approach as he/she attempts new marketing activities. When the firm reaches stage 4, (integrated proactive marketing) "it is normally in a position to employ a marketing expert of its own, full time" (Carson, 1985, p. 14).

The Carson model (1985) was further refined (Carson, 1990, 1993) within the four "distinct stages of marketing development", namely reacting (to customer enquiry and demand until "sales/profits level off or decline"); tinkering (by the owner/manager with marketing techniques to improve the situation); entrepreneurial (the entrepreneur concentrates most of his/her efforts on marketing); and proactive (when the firm employs professional marketing expertise). Carson (1985, p. 15) is the first to explain that "not all firms will conform to this model". One

reason for this is because the model is based on the assumption that the goal of all small firms is to evolve based on sales growth and in order to achieve that there is a need to employ marketing expertise. That is not a universal truth- precisely one of the attributes of small businesses (Schollhammer and Kurilof, 1979) is the independence the owner/manager has and how that impacts on choosing not to grow and on the management style, in particular the lack of sharing of decision making.

Figure 2.2 below shows the Carson Model for Development of Small Firm Marketing, based on a compilation of the work undertaken by Carson (1985, 1990, 1993).

Figure 2.2 The Carson Model For Development of Small Firm Marketing



#### Marketing Activity:

##### **Stage 1:**

Simply reacting to customer inquiry and demand. Mostly based on personal contacts, word of mouth recommendation, practically no promotional support, minimal selling activity.

##### **Stage 2:**

Spontaneous, uncoordinated attempts to increase sales by “tinkering” with marketing techniques (ie. occasional local advertising and brochures)

##### **Stage 3:**

Owner-manager learns about marketing and recognizes its value in generating extra sales, thus carrying out “instinctive” marketing.

##### **Stage 4:**

Professional marketing in coordinated and integrated manner carried out by hired marketing expert.

The main focus of the Carson Model is that, over time, sales increase as a result of an evolution of the marketing activities. Initially based mostly on personal contacts and word of mouth recommendation with practically no promotional support, the marketing activity evolves as the owner/manager carries out "instinctive" marketing. Finally growth is achieved as professional marketing expertise is contracted to carry out effective marketing for the firm.

For this research, the Carson model for development of small firm marketing was adapted to include key characteristics of small professional service practices found in the literature. The following sections summarize the aspects relating to the external environment (section 2.8.4) and the internal environment, including personal characteristics of the owner/manager of the professional service practice (section 2.8.5). Both environments are included in the proposed model for marketing in small professional service firms (section 2.8.6).

#### **2.8.4 External Environment**

In the particular case of professional services, as explained in section 2.5, significant changes have occurred in the services sector, including changes in the regulations that limited the use of marketing for various types of professional service practices. These external environmental factors produce tremendous pressure for professional service firms of all types to consider the role that marketing may play in the management and strategic direction of their business (Piercy and Morgan 1989a, 1989b). Therefore, it is important in this research to consider the external environment in which the professional service practices under study operate. Davidsson and Wiklund (1999) effectively argue about the importance of taking environmental influences into consideration, particularly in studies of small enterprises. Given the high death ratio of smaller businesses (Davidsson et al., 1994), the resultant implication is that the small firm is very vulnerable to influences from the environment (Storey, 1994). According to Carson (1993) "...a small firm is at its most vulnerable at the reactive and tinkering stages (stages 1 and 2 in

figure 2.2). It is here that the firm may succumb to any number of environmental adversities because it is ill equipped to deal with these in any meaningful sense" (p. 197). Besides being a threat to small firms, the environmental factors can also represent opportunities (Davidsson, 1989; Stevenson, 1984; Stevenson and Gumpert, 1991; and Stevenson and Jarillo, 1986; 1990). In their examination of the future of small businesses in the United Kingdom, Curran and Blackburn (1991) focused on "...a number of structural changes which will impinge on the activities of small firms" and argue that "contextual factors" are "often ignored in the analysis of the small business..." (p. 164). Chapter 4 provides a description of the situation in the region/area under study, highlighting the rapidly changing external environment under which the professional service firms under study operate.

Tushman and Romanelli (1985) maintain that in order for firms to achieve high performance different strategies are required given different environments. Others (Davidsson and Wiklund, 1999; and Child, 1972) argue that the owner/manager is free to choose among various strategies to pursue under the same environmental conditions, thus the activities they undertake may depend on the environment, but are not completely determined by it. Therefore, in addition to the external environment, the attitudes and motivation of the business owner (which is categorized in the literature as part of the internal environment in the small firm) needs to be taken into consideration.

#### **2.8.5 Internal Environment**

The literature does mention that in essence the owner's goals equate with the business goals at the early stages of the firm (Churchill and Lewis, 1983; Gibb and Davies, 1990; and Scott and Bruce, 1987) but, as the company evolves through its life cycle, the need for growth dictates the company's goals. The personal characteristics of the small firm owner, however, may also continue to impact on the firm's development later on (Scott and Bruce, 1987). "Not all



businesses that survive grow to be large businesses. This is due either to the nature of their industry or simply the personal desires or ambitions of the owner/manager" (Scott and Bruce, 1987, p. 45).

Understanding the attitude of the small business owner towards marketing, both, in the beginning of the business life cycle as well as later on, could help understand his/her possible use (or lack of use) of marketing for the practice. Carson (1985, pp. 12-13) emphasizes that in stage two of his model for development of small firm marketing (figure 2.2) the pressure to grow *"...can bring about a fundamental change in the attitude of the owner/manager of the small firm ... this change in attitude seems crucial to the future expansion and development of the small firm - and the approach the small firm adopts towards marketing issues... Bearing in mind the change in attitude towards marketing that has frequently occurred ...(in stage two, the owner/manager starts)...to find out something about marketing and starts to dabble in new marketing activity."* As previously explained in section 2.5, the literature argues that the attitudes and opinions of professional service providers (including physicians) towards advertising their practice are negative (Darling and Hackett, 1978; Hite and Fraser, 1988; McCann et al., 1993; Miller and Waller, 1979; Stevens et al., 1990). In the case of small professional service firms the attitude of the service provider appears particularly relevant, as in services (vis-a-vis products) the service provider plays a key role in the service delivery process and thus is, to a large extent, the service itself (section 2.4). The identification of attitudes of the entrepreneur in small and medium firms has served as the basis for research that utilises the life cycle model. Recent examples include a study of industrial SMEs in Finland (Halttunen, 1999) and of leading growth oriented firms in Ontario, Canada (Rumball, 2000). Chapter 3 (sections 3.4.3.2 and 3.4.3.6) explains the methodology utilised to measure attitudes of physicians surveyed and analyse if their attitudes towards marketing impact on the marketing they undertake (or fail to undertake) for their professional practices.

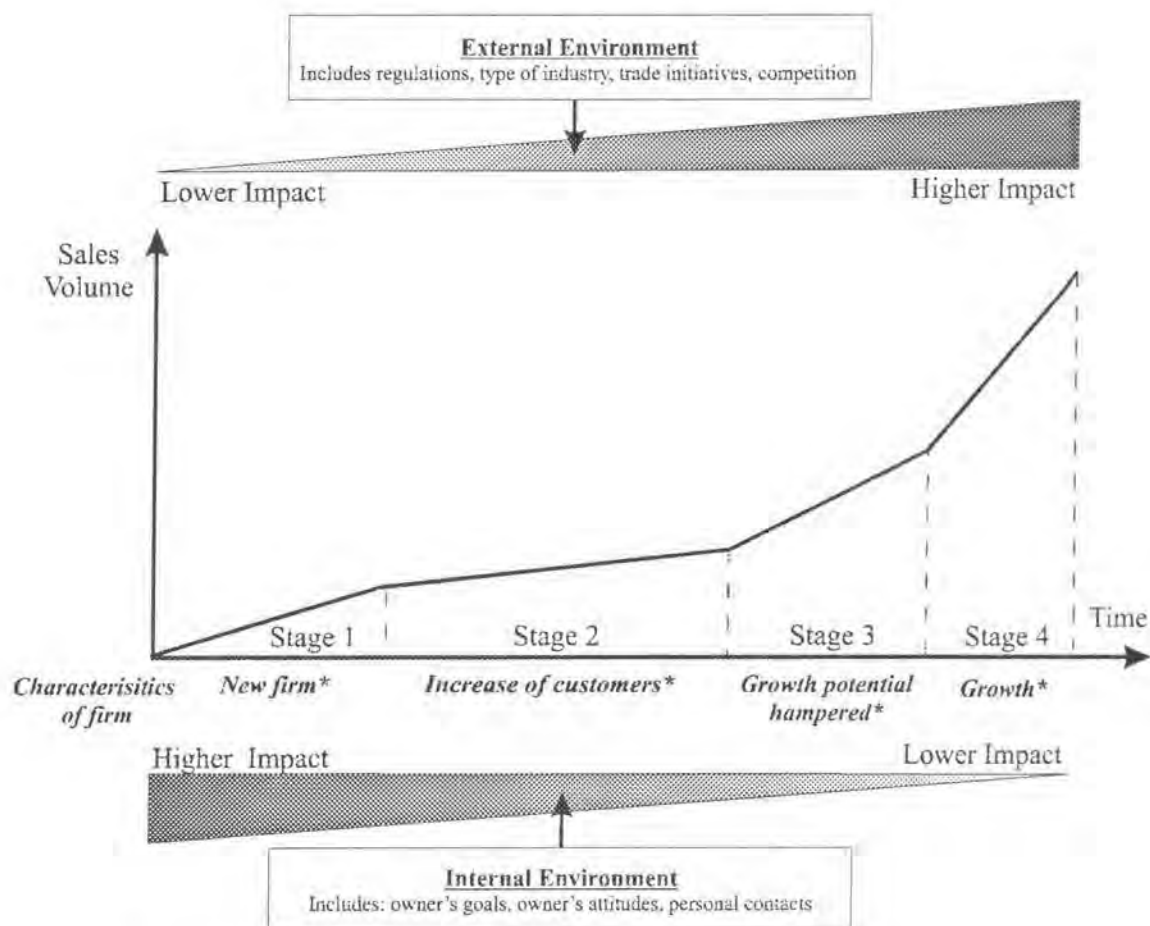
Another factor having to do with the internal environment that should be considered is the personal contact network. Whether at the initial growth phase (stage 1) as suggested by Carson (1985, 1990) or at any other stage in its life cycle, the marketing activities of the small firm that are based on personal contacts are referred to in the literature as "personal contact networks". Studies about the nature of personal contact networks (Aldrich et al. 1989; Mintzberg 1973; Johannisson 1984, 1986, 1987a, 1987b, 1988a, 1988b; Johannisson and Peterson 1984; Aldreich and Zimmer 1986, Dubini and Aldrich, 1991) have found that the key characteristic is that the entrepreneur knows the person in his/her personal contact network, and that such a personal network operates on an informal basis.

Dealing with the factors of the environment surrounding the firm, as well as the individual factors of the entrepreneur, is part of the tasks to be performed by the small firm owner/manager. According to Rea et al. (1999, page 7) "successful firms are the consequence of a good combination of environmental and individual factors...". In the literature, however, minimal importance is attributed to the interaction among the environmental and individual factors (Chandler and Hanks, 1994). Chapter 4 explains the situational analysis for this research in order to understand the various changes taking place in the external environment where the small professional service providers operate. It includes various changes that have taken place in regards to the regulations and how trade associations initiate and/or react to changes in the market, particularly related to the marketing of the professional service practice under study. Thus it provides the contextual framework to understand how this external environment interacts with the internal environment under the control of the small business owner.

### 2.8.6 Model for Marketing in Small Professional Service Firms

The model for marketing in small professional service firms (figure 2.3) was developed by incorporating into the Carson model (figure 2.2) the factors relating to the external environment (section 2.8.4) and the internal environment (section 2.8.5). It has been adopted as the general framework for the research.

Figure 2.3 Model for Marketing in Small Professional Service Firms



\*Marketing activity for the respective stages are the same as those included in Figure 2.2 (Carson's Model for Development of Small Firm Marketing)

The Model for Marketing in Small Professional Service Firms shows that the initial role of the owner/manager changes over time. Namely, the personal goals, attitudes towards marketing the professional service practice, and the use of personal contacts, have a higher impact on the firm as it initiates operations and diminishes over time as the firm grows. The external environment, on the other hand, has an increasing impact on the marketing activities of the firm as it grows. Changes in industry practices (including those resultant from an increase or decrease of regulations) and competitive pressures, among other external factors, increasingly require the enterprise to adopt advanced marketing activities in order to survive and grow in the changed competitive environment.

The Model for Marketing in Small Professional Service Firms, above, is used as the general framework to conduct the research. Chapter 3 explains the research design and methodology.

## **2.9 SUMMARY**

The literature review establishes marketing as a customer centred, ongoing process of satisfying consumer needs. The growth of competition in all sectors, including services in general and professional services in particular (including health services), further requires attention to be focused on the client to attract and retain him/her as a customer.

The particular differences between products and services (including greater involvement of customers in the production process, people as part of the product and greater difficulties in maintaining quality control standards) has resulted in considerable research in the area of service marketing.

The growth of literature in the area of services marketing has evolved into specific focus areas which tend to be clustered (Fisk et. al., 1993) under five specific topics: service quality, service encounter/experiences; services design; customer retention and relationship marketing; and internal marketing. These focus areas of services marketing research provide the theoretical context for the investigation.

The literature suggests that the emphasis of marketing in the health services sector has been in the area of the larger organizations and the broader public health issues. However, the health care industry has not been excluded from the types of changes previously mentioned which have had a significant impact in other organisations, including an increase in competition (Kotler and Clarke, 1987). Further the legal resolution of codes of professional ethics that banned direct client solicitation, advertising and price competition from the practice of professional services (including physician services) has had the result of allowing marketing for several professions. Given the growth of competition in the sector, this could tend to increase the use of marketing practices for physician services.

The literature argues that customers have accepted the use of marketing for professional services, although professional service providers appear to hold negative attitudes towards the use of marketing for their practice. The literature further suggests that service providers believe marketing is not necessary particularly for the professions in small practice (Kotler 1994). In fact most service providers researched after the elimination of the restrictions that banned marketing activities equate marketing with advertising. Thus it appears that service providers have no clear understanding of marketing, namely that marketing is mostly advertising. This tends to support the notion that if the service provider disagrees with marketing he/she will not use it for the practice.

Since most of the research about the attitudes of service providers towards marketing was done shortly after the restrictions were banned, it could be argued that the respondents' answers were the result of having been schooled in, and by operating under, the belief that such activities were not appropriate. Therefore, service providers new to the market place could have a different set of beliefs towards the marketing of their practices.

The literature of small firm marketing is limited despite the significant impact of small businesses in the economy. It argues that smaller enterprises have limitations and constraints which suggest that their marketing behaviour is different to that of larger firms. Research to understand why small firms behave differently and how they evaluate and make marketing decisions and how these are implemented and monitored was found to be lacking. A major problem for studying and understanding marketing in small firms is the absence of appropriate small business marketing theory. Carson (1985, 1990, 1993) has proposed a model for the development of small firm marketing (figure 2.2) whose focus is that, over time, sales increase as a result of an evolution of the marketing activities. Initially based mostly on personal contacts and word of mouth recommendation with practically no promotional support, the marketing activity evolves as the owner/manager carries out "instinctive" marketing. Finally growth is achieved as professional marketing expertise is contracted to carry out effective marketing for the firm.

For this research, the Carson model for development of small firm marketing has been adapted to include key characteristics of small professional service practices found in the literature. Namely, aspects relating to the external environment and the internal environment, including personal characteristics of the owner/manager of the professional practice. The Model for Marketing in Small Professional Service Firms (figure 2.3) shows that the initial role of the owner/manager changes over time, having a higher impact on the firm as it initiates operations

and diminishing over time as the firm grows. The external environment, on the other hand, increasingly requires the enterprise to adopt advanced marketing activities in order to survive and grow in the changing competitive environment. The resultant model for marketing in small professional service firms was developed (figure 2.3) as the general framework to conduct the research.

Based on the findings from the literature review, as explained above, the areas to be studied have been identified and the theoretical context for the investigation established. The research aims to understand why small professional service firms behave as they do in terms of marketing their practice, how they decide, implement and monitor marketing activities utilising a case study of physicians in small practices in Puerto Rico. To do this, the small firm marketing model developed by Carson (1985, 1990, 1993) has been adapted (section 2.8) to include key characteristics of small professional service practices found in the literature. The findings of the research, should thus provide information particular to the development of knowledge in the areas of services marketing, professional services, and marketing of smaller enterprises as well as the interface of marketing with these. Based on this framework, the research methodology (chapter 3) has been developed.

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## **CHAPTER 3**

### **RESEARCH DESIGN AND METHODOLOGY**

#### **3.1 INTRODUCTION**

Chapter 2 established marketing as a customer centred, ongoing process of satisfying consumer needs. The growth of competition in all service sectors, requires a customer focus in order to attract and retain the client (Kotler, 2000). It can be argued then that the whole objective of a professional service provider is to satisfy customer/client needs.

As the literature review has shown, the last 20 years have witnessed the emergence and development of a body of knowledge to address the particular differences of marketing services vis-a-vis products. This has been stimulated by the growth of the service sector, the deregulation of the service industries, and the resultant increase in competition (Berry and Parasuraman, 1993). Within this framework, the area of professional services marketing has been stimulated by the removal of restrictions previously imposed on marketing practices, including advertising (Milliman and Fugate, 1993). The particular differences of services (vis-a-vis goods) and of smaller enterprises, which are addressed in Chapter 2, make professional service practices particularly suited for a market orientation which includes the service itself as well as the service provider which are inseparable in the case of professional services, particularly in smaller enterprises.

#### **3.2 DISCUSSION OF THE PROBLEM**

The problem, based on the literature reviewed (chapter 2), is that there is an absence of appropriate small business marketing theory in general and the marketing of small professional service businesses in particular. According to the literature reviewed (Schollhammer and

Kurilof, 1979; Stash and Ward, 1987; Davies et al., 1985; Romano and Ratnatunga, 1995; Siu and Kirby, 1998) there is a lack of research to understand why small firms behave differently from larger firms, how they evaluate and make marketing decisions, and how these are implemented and monitored. For small professional service firms the lack of research in this direction is a problem, as competition in the service industry increases, since it is expected that the larger professional service enterprises will successfully evolve to a marketing orientation, a trend experienced in other industries as competition has increased. The smaller professional service firm that fails to embrace a marketing orientation is likely to be disadvantaged in the marketplace and may end up being in a reaction mode, compared with the larger professional service firms and their marketing actions. An early marketing orientation for the smaller professional service firm, which focuses on meeting customer need is, therefore, in the best interest of the service provider and of the customer.

### **3.3 PURPOSE OF THE STUDY**

The purpose of this study is to examine the roles played by the key components of the external and internal environment of the small professional service firm have in the process of adopting (or failing to adopt) a marketing orientation. The general framework to conduct the research, based on the literature reviewed (section 2.8) is the Model for Marketing in Small Professional Service Firms (figure 2.3) which incorporates both the external and internal environment to Carson's Model for the Development of Small Firm Marketing (1985, 1990, 1993).

The research examines the perceptions professional service providers in smaller enterprises have about marketing their private practices, what they understand marketing is, what they do and how this is done. The interest is in finding out what practitioners understand by the concept of marketing, what aspects of marketing they practise most, the extent to which they

adopt a market orientation, and why they agree or disagree with the use of marketing for their practices, why they undertake (or fail to undertake) marketing activities and how they go about deciding, implementing and monitoring such activities.

The intent of this process is to enhance both the theory and practice of the marketing of small professional service enterprises. The purpose, then, is for this research to further the body of knowledge on the marketing of small professional service enterprises and to evaluate how that body of knowledge on the subject explains, or fails to explain, the findings.

To facilitate this investigation, physician's services in Puerto Rico were taken as a case example mainly because of the impact the significant changes in the external environment in that industry/region can place on the operation of their small professional service firms. Chapter 4 offers an overview of the situation in the region/area where the field work for the research takes place.

The study specifically intends to:

- a) consider how physicians undertake marketing and the beliefs and attitudes they have about marketing their practices.
- b) determine the role of marketing in the physician's private practice.
- c) identify some of the relevant factors related to the attitudes of physicians towards the use of marketing in their practice.

The findings of the study are compared with the existing body of knowledge on professional services and small firm marketing in order to refute/corroborate the existing body of understanding thereby furthering knowledge. The findings are used to evaluate the Model for

Marketing in Small Professional Service Firms (figure 2.3) used as the general framework to conduct the research and propose changes, as needs be.

### 3.4 RESEARCH DESIGN

#### 3.4.1 Overview of Research Design

A research design is a plan designated for collecting and analysing information or data (Zigkmund, 1988, and Churchill, 1979). Kinnear and Taylor (1991, p. 135) suggest that:

*"An effective research design assures that the information gathered is consistent with the research objectives and that the data collection and analysis phases involve accurate and economical procedures".*

As Simon (1969, p. 4) observes:

*"There is never a single, standard, correct method of carrying out a piece of research. Do not wait to start your research until you find out the proper approach, because there are many ways to tackle a problem- some good, some bad, but probably several good ways. There is no single perfect design. A research method for a given problem is not like the solution to a problem in algebra. It is more like a recipe for beef stroganoff; there is no one best recipe".*

The methodology for this research was designed to allow for the collection and analysis of data that were consistent with the objective of the investigation. Particular emphasis was placed on developing a combination of methodologies that made the task at hand actionable, given the time and resources available.

This research design consists of three phases each utilizing methodology and instruments considered appropriate for the particular phase of work. Phase one (section 3.4.2) consists of the literature review (chapter 2) which identifies what is known and provides the theoretical context for the investigation, and an analysis of the area/region under study via secondary data (chapter 4) to understand the particulars of the industry/area where research takes place and to provide the situational context upon which to analyse the findings. The literature review (sections 2.5 and 2.6) revealed questionnaire surveys had been utilised (mostly in the (1980's) to explore the attitude of professional service providers towards marketing in general and its use for professional service practices in particular. Given the nature of the literature review, the researcher understood it was better to do a survey to update the findings of the literature and then conduct case analysis to get more insights to what emerged from the literature and the survey. Phase two thus, is the quantitative research (section 3.4.3) by means of a questionnaire administered to a sample of physicians in Puerto Rico. This phase of the research includes testing a series of hypotheses derived from statements drawn from the literature (sections 3.4.3.2 and 3.4.3.6), which include aspects dealing with both the external and the internal environment of the professional service practice (figure 2.3). This phase of the research design helps to set the context for qualitative research based case studies (phase three of the research-section 3.4.4). Phase three of the research design clarifies the concepts that emerged from the literature review (phase one) and the analysis of the survey (phase two) and further evaluates the model for Marketing in Small Professional Service Firms (figure 2.3) utilised as the general framework for the research.

### **3.4.2 Phase One: Literature Review and Analysis of the Area under Study**

The literature review undertaken (Chapter 2) has focused on services marketing, professional services marketing and marketing for smaller enterprises in an effort to determine the body of



understanding and identify and provide the theoretical context for the investigation. In order to understand the particulars of the area where the research is to be conducted and provide the situational context upon which to analyse the findings, an analysis of the area under study has also been conducted via secondary data (chapter 4). Chapter two provides the summary of the literature review undertaken and chapter four describes the analysis of the area under study.

The review of the literature provides the theoretical context for the investigation and helps formulate the general framework to conduct the research: the resultant Model for Marketing in Small Professional Service Firms (figure 2.3) incorporates both the external and the internal environment to Carson's Model for the Development of Small Firm Marketing (1985, 1990, 1993). Based on the general framework for the research, and given the time and resources available, a combination of quantitative (section 3.4.3) and qualitative methods (section 3.4.4) have been employed to carry out the investigation.

### **3.4.3 Phase Two: Quantitative Research**

#### **3.4.3.1 Introduction**

Phase two of the research design consisted of quantitative research by means of a questionnaire (appendixes 1 and 2) administered to a sample of physicians in Puerto Rico. The translation of the questionnaire into Spanish was back translated to ensure the statements posed to the sample were comparable. The questionnaire included classification data and allowed respondents to self report by means of Likert type attitude scale (section 3.4.3.2) their level of agreement with forty one statements drawn from the literature, as explained in section 3.4.3.3. The objective of this phase of the research was not only to examine the level of agreement of the physicians with the statements but their use of marketing. The analysis included conducting a series of

hypothesis tests (explained in sections 3.4.3.3 and 3.4.3.6) which included aspects dealing with both the external and the internal environment of the professional service practice (figure 2.3). With this quantitative research the degree of association between the physician's attitudes about marketing their practice and the variables under study (section 3.4.3.5) was determined. This phase of the research design helped to set the context for phase three (section 3.4.4) qualitative research based case studies.

### **3.4.3.2 Attitude Scale**

An attitude presents a person's ideas, convictions, or liking with regard to a specific object or idea (Churchill, 1979). As Schreier (1963, p.273) comments "attitudes may be said to be the forerunners of behavior" mainly because they are "believed to strongly influence behaviour" (Churchill 1999, p. 378). Thus, studying attitudes provide an assessment of a "person's posture on an issue" and is, therefore used as "an important explanatory variable in creating models of behaviour" (Churchill 1999, pp. 378-380). In the case of this research understanding the attitudes of the professional service providers towards marketing, based on the literature review (section 2.6), provides an understanding of the behaviour of the service provider to undertake or not to undertake marketing for their practices.

The general methods of attitude measurement can be divided into those based on observing respondents and those based on communicating with respondents. The most common tool of attitude measurement is the self report (Kinnear and Taylor, 1991) whereby respondents are asked to report directly their beliefs by responding to questions on a questionnaire.

The questionnaire utilised in this phase of the research asked respondents to self report their level of agreement with the statements drawn from the literature (section 3.4.3.3) by means of

a Likert scale. The Likert scale has various advantages over other scaling techniques, namely that it is easy to administer, the instructions are simple, and a rather lengthy number of items can be evaluated (as was the case for this survey) because there is only one uniform set of rating categories for the person to use. The five-point scale was more advantageous to utilize for this survey, vis-a-vis a three or seven point scale (for example), for various reasons. A practical reason was that a five point scale allowed for better comparison with the original research from where the statements were drawn. A methodological reason, on the other hand, was that as the number of response categories grows, there is an increase in the possibility that some cells do not satisfy the requirements to apply a chi-square test (section 3.4.3.6). Additionally, a five point Likert scale allows the researcher to examine in detail the responses given, enabling the researcher to discriminate among the physicians with positive, negative and neutral attitudes towards marketing their practices.

#### **3.4.3.3 Hypotheses**

The literature review (chapter 2) identified a series of research undertaken to understand the attitudes of professional service providers, including physicians, towards the use of marketing for their practices. Survey questions from various research found in the literature (chapter 2), as well as other statements drawn from the literature, were utilised as the basis for formulating the various hypotheses for this phase of the research. This was done because not only did they address various aspects of the issue at hand but the responses to the questionnaire by the physicians surveyed could be compared to the findings in the literature. The statements included in the questionnaire, which serve as the basis for the hypotheses (explained further below) can be grouped into the following categories, following the Model for Marketing in Small Professional Service Firms (figure 2.3) utilised as the general framework to conduct the investigation:

**Internal environment:** includes items regarding aspects within the control of the service provider in terms of

- general statements regarding marketing, marketing of service firms, marketing of smaller enterprises, the marketing concept. These statements were taken from Kotler 1991 and 1994 (section 1.2) and are included in the questionnaire (appendixes 1 and 2) as items 8, 9 and 10. The aspect of customer orientation (sections 2.3 and 2.5) is included as items 13 and 43 in the questionnaire.
- statements regarding specific areas of marketing (relationship marketing, part-time marketers, personal contact network). The statements regarding relationship marketing (section 2.4 and 2.4.4) are mostly adopted from Shimp and Dyer, 1978 (included in the questionnaire as items 44) and from Aponte et al. 1974 (section 4.5) included as item 45 in the questionnaire. The statements regarding part-time marketers (section 2.4) were based on Gummesson 1987, 1990 and are included in the questionnaire as items 22 and 23. The statements regarding personal contact network (section 2.7) were based on Aldrich et al. 1989; Mintzberg 1973; Johannisson 1984, 1986, 1987a, 1987b, 1988a, 1988b; Johannisson and Peterson 1984; Aldrich and Zimmer 1986, Dubini and Aldrich, 1991. Items 47 and 48 in the questionnaire address the area of personal contact network.
- statements regarding marketing of physician services were drawn from research about physicians. These statements were mostly from Korgaonkar 1985 (section 2.6) and are included in the questionnaire as

items 11, 13, and 16 to 21 (inclusive). To probe about physicians' vision of service and management of service quality, item 15 was included, drawn from Crane, 1993 (section 2.5). Statements regarding the marketing of physician services were also drawn from research regarding physicians and other providers of professional services (lawyers, accountants, dentists) (section 2.5). These statements were mostly adopted from Hite and Bellizzi, 1996 (item 14 in the questionnaire); Shimp and Dyer, 1978 (items 31, 32, 33, 35, 44, and 46 in the questionnaire); Busson and Darling, 1978 (items 25, 26, 28, 34); and a combination of various research (ie. item 24 in the questionnaire drawn from Busson and Darling 1978, Shimp and Dyer 1978, and Korgaonkar 1985).

**External environment:** includes items regarding aspects outside the control of the service provider, such as

- statements regarding health services and health reform are drawn from research in the area under study (chapter four). Most of these statements were from Aponte et al. 1974 (section 4.5) and are included in the questionnaire as items 29, 30, 37, 40, and 45. Other items (38, 39, 41 and 42) were developed based on the health reform programme underway on the region under study (section 4.5) (Friedman, 1993). Items regarding competition were drawn from Crane, 1993 (section 2.5) and is included as item 36 in the questionnaire, while item 27 is adopted from Busson and Darling, 1978.

Other aspects having to do with both the internal and the external environment, as well as the interaction between them, were explored after the analysis of the survey, in phase three of the

research (section 3.4.4). Thus, as previously mentioned (section 3.4.3.1), the quantitative phase of the research design (phase two) helped set the context for the qualitative phase of the research, based on case studies.

As previously explained (section 3.4.3.2) a Likert scale allowed the respondents to indicate their attitudes towards the various statements by checking how strongly they agreed or disagreed with each of the statements. The physicians were required to select from a five-point Likert-type scale, utilising the following statements: "strongly agree", "agree", "neither agree nor disagree", "disagree", and "strongly disagree". This was codified in the questionnaire as follows: 5 equals "strongly agree"; 4 equals "agree"; 3 equals "neither agree nor disagree"; 2 equals "disagree"; and 1 equals "strongly disagree". The resulting means of the respondents' answers were tested for significance against the scale's median of 3 (neutral). This methodology for testing statements is drawn from the literature where the Likert scale has been utilised in recent marketing and small business research (Geursen and Conduit, 2000). The hypotheses, therefore, were formulated in terms of the scale's median of 3, based on the findings of the literature review. In cases where the literature indicated respondents were in agreement with an statement, the hypotheses was stated as  $H_0: \mu \geq 3$  and  $H_1: \mu < 3$ ; in cases where the literature indicated respondents were in disagreement, the hypotheses was stated as  $H_0: \mu \leq 3$  and  $H_1: \mu > 3$ ; and in circumstances where the literature showed neither agreement nor disagreement (or neutral) with a statement, the hypotheses was stated as  $H_0: \mu = 3$  and  $H_1: \mu \neq 3$ .

The following table (table 3.1) provides the number corresponding to the statements in the questionnaire (appendixes 1 and 2), the hypothesis as well as the relevant literature from where the statement and hypothesis was drawn.

**Table 3.1 Hypotheses to be tested with questionnaire**

<u>Number and statement in questionnaire</u>	<u>Hypothesis</u>	<u>Literature</u>
8. Marketing is not for professionals.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Kotler (1994): the use of marketing is not for the professions
9. Marketing is necessary for service firms.	$H_0: \mu \leq 3$ $H_1: \mu > 3$	Kotler (1994): marketing is not necessary for service firms
10. Formal marketing is not needed for small firms .	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Kotler (1994): many firms view themselves as too small to use formal marketing.
11. Marketing is mostly advertising and promotion.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Korgaonkar (1985): most physicians surveyed defined marketing by equating it to advertising (90%) and sales promotion (83%).
12. It is difficult to agree with modern marketing practices.	$H_0: \mu = 3$ $H_1: \mu \neq 3$	Korgaonkar (1985): most physicians responded neither "agree nor disagree" to: "it is difficult to identify with marketing practices of business today".
13. A good marketer is mostly oriented towards understanding his/her customers needs	$H_0: \mu \geq 3$ $H_1: \mu < 3$	(Kotler 94) general orientation of the marketing concept.
14. It is proper for physicians to market their practice.	$H_0: \mu \leq 3$ $H_1: \mu > 3$	Hite and Bellizzi (1986) asked consumers "it is proper for (accountants, lawyers, and physicians) to advertise" and concluded "consumers had a favourable attitude towards professionals with regards to advertising" (p. 47).

Since this research was to interview physicians (not consumers) the hypothesis was formulated given the prevailing attitude of disagreement of physicians, as explained in other literature presented here.

15. Medical providers have a clear vision about the concept of service.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Crane (1993) advocates the need for professional service providers to have a clear vision of the concept of service in order to survive in an increasingly competitive environment.
16. Generally speaking, medical professionals who use marketing techniques probably provide inferior patient care.	$H_0: \mu = 3$ $H_1: \mu \neq 3$	Korgaonkar (1985): physicians' responded neutral to same statement (35% agree, 34% neutral, 31 % disagree).
17. Marketing by medical professionals will help them to be more responsive to the client's needs and wants.	$H_0: \mu \leq 3$ $H_1: \mu > 3$	Korgaonkar (1985): largest group of physicians interviewed (44%) - disagreed/strongly disagreed with same statement (29 neutral, 27 % agree).
18. Marketing by medical professionals will lower the status of the profession.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Korgaonkar ( 1985): majority of physicians interviewed (55%) agree/strongly agreed with same statement.
19. For better or worse, marketing will play an important role in future development in the medical profession.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Korgaonkar (1985): great majority of physicians (78%) agreed/strongly agreed with same statement.
20. In the future, medical professionals will benefit by understanding more about marketing.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Korgaonkar (1985): majority of physicians (62%) agreed/strongly agreed with same statement.
21. Medical students should be exposed to marketing in order to better prepare them to establish their practice or career.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Korgaonkar (1985): majority of physicians (60%) agreed/strongly agreed with same statement.
22. Physicians should perform marketing functions, formally or informally, for their practice.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Gummeson (1987, 1990): statement to probe the "part-time marketer" concept which Gummeson advocates.
23. The medical staff members should perform marketing functions, formally or informally, for their practice.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Gummeson (1987, 1990): statement to probe the "part-time marketer" concept which Gummeson advocates.



24. Marketing usually increases the price of the product or service offered.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	<p>Busson and Darling (1978, question 8, p.114) asked “advertising of (accountants attorneys, dentists, physicians) usually increases the price of the product or service being advertised.” The mean answer from physicians is 3.76 (where 3 is uncertain and 4 is agree).</p> <p>Shimp and Dyer (1978, page 78) asked attorneys “prices of legal services would decrease if legal services advertising were permitted.” The majority of attorneys (58.3%) disagreed.</p> <p>Korgaonkar (1985) asked physicians “advertising and promotion costs rise the price consumer has to pay for a product or service.” The great majority of physicians (80%) agreed/strongly agreed.</p>
25. The marketing of fees would adversely affect the public image of physicians.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	<p>Busson and Darling (1978, question 10,p.114) asked “The advertising of fees would adversely affect the public image of (accountants, attorneys, dentists, physicians)” and obtained a mean of 3.83 amongst physicians (where 3 is uncertain and 4 agree).</p>
26. Marketing my professional services as a physician would be beneficial to me personally.	$H_0: \mu \leq 3$ $H_1: \mu > 3$	<p>Busson and Darling (1978, question 19,page 114) asked “advertising my services would be beneficial to me personally.” Physicians sampled obtained a mean of 2.21 to this statement (where 2 is disagree and 3 is uncertain).</p>
27. Restrictions on marketing limit competition by refusing to allow physicians to market their services and engage in competitive pricing.	$H_0: \mu \leq 3$ $H_1: \mu > 3$	<p>Busson and Darling (1978, question 9,page 114) asked “restrictions on advertising limit...” (same as our statement in this research) and obtained amongst physicians a mean of 2.05 (where 2 is disagree and 3 is uncertain).</p>

28. It is very difficult to market competence and quality of service in my profession.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Busson and Darling (1978, question 7, page 114) asked "It is very difficult to advertise competence and quality of services in my profession." Physicians sampled obtained a mean of 4 (agree).
29. The majority of physicians that continue to be employed by the public health system are not very competent.	$H_0: \mu \leq 3$ $H_1: \mu > 3$	Aponte et al. (1974) asked the same question and "the great majority of physicians... disagree with this statement" (page 668).
30. Working "part-time" with the government health system adds prestige to the physician	$H_0: \mu = 3$ $H_1: \mu \neq 3$	Aponte et al. (1974) asked the same question and "the opinion of physicians agreeing or disagreeing with that statement is more or less divided equally" (page 669).
31. The marketing of medical services would tend to intensify client dissatisfaction after services have been rendered.	$H_0: \mu = 3$ $H_1: \mu \neq 3$	Shimp and Dyer (1978, page 79) asked attorneys "the advertising of legal services would tend to intensify client dissatisfaction after services have been rendered." The largest percentage of attorneys answered no opinion (28.5%) and the distribution was of responses was very disperse.
32. The marketing of medical services would confuse rather than enlighten potential patients.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Shimp and Dyer (1978, page 79) asked attorneys "advertising of legal services would confuse rather than enlighten potential clients." The majority of attorneys agreed (55.9%).
33. The marketing of medical service would assist potential clients in knowing which physicians are competent to handle particular medical problems.	$H_0: \mu \leq 3$ $H_1: \mu > 3$	Shimp and Dyer (1978, page 79) asked attorneys "Legal service advertising would assist potential clients in knowing with lawyers are competent to handle particular legal problems." The majority of attorneys (58.8%) disagreed.
34. Marketing techniques in general, are a valuable instrument to communicate to patients.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Busson and Darling (1978, question 1, page 114) asked "advertising, in general, is a valuable way to communicate to consumers." The mean answer from physicians is 3.75 (where 3 is neutral and 4 is agreement).

35. The quality of medical services improves when marketing techniques are permitted.	$H_0: \mu \leq 3$ $H_1: \mu > 3$	Shimp and Dyer (1978, page 78) asked attorneys "The quality of legal services would improve if advertising were permitted." The majority of attorneys (65.7%) disagreed.
36. To compete effectively, physicians should manage service quality more efficiently.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Crane (1993, p. 8) proposed that the "... need to manage service quality, both technical and functional... may be the only way to create differentiation..." from other suppliers of similar services.
37. Those that obtain medical services provided by the government receive the same quality of service as that provided by private medical service providers.	$H_0: \mu \leq 3$ $H_1: \mu > 3$	Aponte et al. (1974) asked the same question and "the great majority of physicians... disagree with this statement" (p. 668).
38. The introduction of the health service card helps low income patients obtain better quality in health services.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Friedman (1993): The health service card was the mechanism utilised to grant low income patients access to health services, which the Government's Health Reform Programme understood resulted in better quality of services.
39. The health reform helps low income patients obtain better quality in health services.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Friedman (1993): Health Reform Programme's objectives included helping low income patients obtain better health services.
40. Government should establish norms and regulations for the to physicians assure quality of health services to the people.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Aponte et al. (1974) asked the same question and "the great majority [of physicians] agree with the premise" (p. 670).
41. The health reform has had a positive impact in my practice.	$H_0: \mu \leq 3$ $H_1: \mu > 3$	Friedman (1993): general perception amongst physicians at the time of the study was that health reform was not going to be positive for their medical practices.
42. When the health reform is completed physicians will have to do more than what is currently required.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Friedman (1993): general perception amongst physicians at the time of the study was that physicians would be required to do more once the health reform programme is established.

43. A good physician is mostly oriented towards understanding his/her patient's needs.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	(Kotler 1994) general orientation of the marketing concept.
44. The physician-patient relationship is personal and unique, and should not be established as a result of pressures exerted by marketing techniques.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Shimp and Dyer (1978, p. 78) asked attorneys "the attorney-client relationship is personal and unique, and should not be established as a result of pressures exerted by marketing techniques". The majority of attorneys (64%) agreed.
45. There are significant differences between the physician-patient relationship in the private sector as compared to that in the public sector.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Aponte et al. (1974) asked a similar question and "around 60% of physicians...understand that there is..."a difference between the physician-patient relationship (p. 669).
46. Existing information sources (i.e. yellow pages, medical lists, etc.) provide inadequate information to guide potential patient's select a physician.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Shimp and Dyer (1978) asked attorneys "existing information sources (ie. yellow pages, association referral services, law list, etc.) provide inadequate information to guide potential client's attorney selection". The majority of attorneys (62.7%) agreed.
47. When other colleagues refer patients to me it is mostly because of how well I am known to my colleagues on a personal basis.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Carson (1985, 1990) and various authors (see section 2.8.5). General orientation of the literature on personal contact networks as it relates to the model utilised as general framework for the research.
48. When referring patients to other colleagues I take mostly into consideration how well I know my colleagues on a personal basis.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	Carson (1985, 1990) and various authors (see section 2.8.5). General orientation of the literature on personal contact networks as it relates to the model utilised as general framework for the research.

The t-test was used to determine if the responses from the physicians surveyed supported the acceptance or rejection of each of the hypotheses. A t-test is appropriate for conducting such analysis in a situation where the variance is unknown and the sample size is over 30 (Weiers, 1998). The results of the quantitative survey are included and explained in detail in chapter five.

#### 3.4.3.4 Field Work- Quantitative Survey

Business research is the systematic and objective process of gathering, recording and analysing data (Zickmund, 1988). A wide range of techniques can be used in collecting the information from the respondents, such as personal or telephone interviews and mail questionnaire surveys. Each method has its own advantages and limitations. In this phase of the research, the quantitative research originally considered included a mail survey of a statistical sample of physicians and telephone interviews with a sample of the non-respondents of the mail survey. This research method was abandoned in favour of a personally administered questionnaire to a convenience sample of physicians- a technique which was more cost effective and took considerably less time to undertake- two important considerations for the research design, particularly important as the research design included the other phases of work presented in this chapter. Another important reason for administering the questionnaire personally was the concern that its length and the hectic schedule of physicians would impact adversely on the response rate to a mail survey.

A further justification for administering the questionnaire directly, however, was the opportunity granted by the Co-ordinators of the General Assembly of the College of Physicians and Surgeons in Puerto Rico. This allowed for physicians to complete the questionnaire at the registration area of the assembly before it began. Given the tense situation of change in the health care sector in Puerto Rico (chapter 4), it was felt that physicians would not be receptive to completing the questionnaire unless a direct, personal approach was utilised, preferably under the approval of their professional body. This methodology is not without drawbacks. A convenience sample is a non probability technique, thus the sampling error cannot be determined objectively. There is no probabilistic way of estimating how representative the physicians surveyed are from the population of physicians. The potential biases of using a convenience sample in this research includes that physicians attending the General Assembly

could be different from those not in attendance and that those that voluntarily responded to the survey may be different in matters relevant to the survey from those that chose not to participate. Given the potential for bias, the findings of this research need to be applied carefully. These problems are not insurmountable, however, as the researcher is aware of such drawbacks and took them into consideration as the analysis of the data was done and utilized other research techniques (sections 3.4.4 and 3.5) to provide for a mechanism of triangulation.

Another matter considered in the research design was the aspect of coding. Coding is the process of identifying and classifying each answer with a numerical score or other character symbol (Selltiz and Dunkelberg, 1965; Churchill, 1979 b; Zickmund, 1988). The two basic rules for code construction, suggested by Zickmund, 1988, were followed. First, the coding categories were exhaustive. Second, they were also mutually exclusive and independent. This means that there was no overlap between the categories so that a response could be placed in only one category.

Through coding, raw data is transformed into symbols, usually numbers that may be tabulated and counted. The transformation is not automatic, however, as it involves judgment on the part of the coder (Selltiz and Dunkelberg, 1965). The assignment of numerical symbols allows the transfer of data from the questionnaire to the computer. To minimise the possibility of error at this stage of the research, the coding undertaken was checked before the data was transferred into the computer.

Prior to the full survey, a pretest of the questionnaire was conducted. According to Churchill (1999), the questionnaire pretest is vital. The pretest provides the real test of the questionnaire and the mode of administration. In addition, data collection should never begin without an



adequate pretest of the instrument. It can be used to assess both individual questions and their sequence (Shelby et al., 1992).

The research pretest was undertaken by personal interview with a sample of ten physicians in order to provide information about the effectiveness of the research instrument. The information gathered from these interviews provided some suggestions on how to develop the range of categories for the answers to the classification questions. In addition, the pretest revealed the need to improve the sequence of questions, to provide space for additional comments and to add an introductory statement to provide the respondent with an overview of the purpose of the survey.

Finally, the responses were coded and tabulated. According to Churchill (1999), the tabulation of pretest responses can check on the conceptualisation of the problem and the data and method of analysis necessary.

#### **3.4.3.5 Variables Under Study**

The responses obtained are compared with the results of the original research from where these are drawn and analysed against a series of variables. Section 3.4.3.6 below presents how these are analysed. The variables included in the analysis and the rationale for their inclusion are as follows:

- Years in the profession: Given the relatively recent lifting of the ban on marketing activities, including advertising, perceptions of, and attitudes towards, marketing might vary between those just entering the profession and those that have been in practice for longer periods of time. According to the model used as the general framework of the research (figure 2.3), as the years the service provider has been

in practice increases, the more likely his/her practice has moved into the various stages of marketing development for the firm.

- Gender: The increase in business ownership by women has contributed to an increase in research on the issue of gender. This variable has been included to assess if gender plays a role in the level of agreement physicians have about marketing their practice.
- Level of agreement with marketing by physicians: Based on the to answers for certain statements in the survey instrument, physicians have been classified as "strongly agree with", "strongly in disagree with ", or "neutral to" marketing by physicians. The particulars of how this was done are explained in section 3.4.3.6. The "level of agreement with marketing" by physicians became a variable upon which the quantitative research was analysed for two major reasons. First, the literature reviewed (chapter 2) suggests that the professional service provider's agreement or disagreement with marketing has an impact on whether marketing is deemed appropriate or utilised for the professional service firm. Secondly, according to the model used as the general framework for the research (figure 2.3), as time goes by the small service firm will evolve to a better understanding and utilization of marketing techniques.

#### **3.4.3.6 Statistical Analysis**

Various statistical analyses were performed with the survey results. The t-test was used to determine if the responses from the physicians surveyed supported the acceptance or rejection of each of the hypotheses (section 3.4.3.3). A t-test is appropriate for conducting such analysis in a situation where the variance is unknown and the sample size is over 30 (Weiers, 1998). The t-test is used to test hypotheses about means, therefore, in this research the respondent's



answers were tested for significance against the median of the attitude scale of three (neutral). This methodology for testing statements is drawn from the literature where the Likert scale has been utilised in recent marketing and small business research (Geursen and Conduit, 2000). For the t-test the statistical package SAS was utilized.

Originally the plan was to perform mean difference test to compare between the research from the literature and this research. This required that the mean and the variance of the research from the literature be obtained. Only the research from Busson and Darling (1978) provide the means, but it lacks the data regarding the variance. The other research in the literature did not provide data on either the mean or the variance. Thus, it was not possible to perform mean difference tests.

The data obtained from the survey was also analysed in terms of the various variables under study, namely “years in the profession”, “gender” and “agreement/disagreement with marketing” (section 3.4.3.5). In the case of the “gender” variable, the purpose was to observe if significant differences exist between gender and the various statements under study. Thus, the null hypothesis regarding the gender variable is  $H_0: \mu_1 = \mu_2$  versus  $H_1: \mu_1 \neq \mu_2$  where  $\mu_1$  is the mean response of male physicians to each statement and  $\mu_2$  is the mean response of female physicians to the same statement. The t-test is appropriate for conducting such analysis in a situation where the variance is unknown and the sample size is over 30 (Weiers, 1998).

In the case of the “years in the profession”, the purpose was to observe if significant differences exist between “years in the profession” and the various statements. Given that six categories of responses were included in the questionnaire (appendixes 1 and 2) for the variable “years in the profession”, the null hypothesis is  $H_0: \mu_1 = \mu_2 = \mu_3 = \mu_4 = \mu_5 = \mu_6$  versus  $H_1$ : not all the means are equal, where  $\mu_1$  is the mean response of all physicians with 0 to 5 years in the profession,  $\mu_2$  is

the mean response of all physicians with 6 to 10 years in the profession, etc. This type of analysis for comparing the means of more than two populations (versus male/female which are two populations) requires the use of one way ANOVA (analysis of variance) (Chase and Bown, 1997).

For measuring the “level of agreement/disagreement with marketing” an option considered was asking physicians to categorize themselves as in agreement, disagreement or neutral about marketing. The concern that a direct question might result in biased responses suggested the need to create a variable from the data in the questionnaire. To do so, four statements included in the questionnaire were selected as representative of the literature which, combined, provided a measure to assist in classifying a physicians’ level of agreement/disagreement with marketing. The selected items had to do with understanding that it is proper to market their practice and that physicians should engage in marketing functions as that would be in the best interests of the clients and themselves. The statements selected were:

- 1- Item 14: “It is proper for physicians to market their practice”
- 2- Item 17: “Marketing by medical professionals will help them to be more responsive to the clients’ needs and wants”
- 3- Item 22: “Physicians should perform marketing functions, formally or informally, for their practice”
- 4- Item 26: “Marketing my professional services as a physician would be beneficial to me personally”.

In order to establish the variable “level of agreement/disagreement with marketing” two analyses were performed, namely correspondence analysis and cluster analysis. Correspondence analysis is used in this research to reduce the dimensionality (number of variables) in order to obtain the principal factors that explain most of the structure of the

variables that will be used for the cluster analysis. Utilizing the factorial coordinates obtained from the correspondence analysis, a hierarchical cluster analysis was conducted. "Cluster analysis (allows us) to sort cases into groups, or clusters, so that the degree of association is strong between members of the same cluster and weak between members of different clusters" (SAS Institute 1989a, p. 519). Through the cluster analysis it was possible to determine three categories of "level of agreement with marketing", namely "strongly in agreement with marketing", "strongly in disagreement with marketing", and "neutral about marketing".

Once three categories have been constructed ("strongly agree", "strongly disagree", "neutral") the goal was to compare the means of the attitude towards the statements from the literature (items 8 to 48 in the questionnaire) of the respondents. Thus, the null hypothesis is  $H_0: \mu_1 = \mu_2 = \mu_3$  versus  $H_1$ : not all means are equal. ANOVA (analysis of variance) was utilized to compare the means of the three populations (level of agreement/disagreement with marketing).

Utilising the three categories that were constructed ("strongly agree", "strongly disagree", "neutral") the data were then analysed to determine if the mean of the responses from the statement differ with respect to the variables "years in the profession" and "type of marketing activity undertaken". With the purpose of determining if there is a relationship between the three categories of "level of agreement with marketing" and the variable "years in the profession" the null hypothesis was established as  $H_0$ : the variable "level of agreement with marketing" and "years in the practice of the profession" are independent; versus  $H_1$ : the variable "level of agreement with marketing" and "years in the practice of the profession" are related. A chi-square test was utilized to determine statistically if there was a relationship between the variables, given that the data under analysis contains variables with more than two data categories (Weiers, 1998).

In order to determine if there is a relationship between the three categories of “level of agreement with marketing” and the “type of marketing activity undertaken” (item number 49 in the questionnaire) the null hypothesis was established as  $H_0$ : the variable “level of agreement with marketing” and “type of marketing activity undertaken” are independent; versus  $H_1$ : the variable “level of agreement with marketing” and “type of marketing activity undertaken” are related. A chi-square test was utilised to determine statistically if there was a relationship between the variables.

The impact of both the internal and the external influences on the evolution of marketing in the small professional service firms, as per the model utilised as the general framework for the research (figure 2.3), was measured against the variable “years in the profession”. It is expected that the more years the service provider has in the profession, the more likely that their practices will be in a more advanced stage of marketing development, according to the model (figure 2.3). To perform this analysis two indexes were developed: one to measure the impact of external variables in the respondents and another to measure the impact of the internal variables in the respondents. To obtain the indexes the PRINQUAL procedure (principal components of qualitative data) and the principal component analysis were utilized. “The PRINQUAL procedures obtains linear and nonlinear transformations of variables using the method of altering least squares to optimize properties of the transformed variables’ covariance or correlation matrix” (SAS Institute 1989b, p. 1265). “The principal component analysis is a multivariate technique for examining relationship among several quantitative variables”. (SAS Institute, 1989b, p. 1240).

Utilizing PRINQUAL and the principal component analysis, each respondent (who was not missing data in the variables used for each index) was given an “index for the external factor” and an “index for the internal factor”. The indexes were then compared to “years in the

profession” of the physicians in order to perform the various hypothesis tests. The null hypothesis is  $H_0: \mu_1=\mu_2=\mu_3=\mu_4=\mu_5=\mu_6$  versus  $H_1$ : not all the means are equal, where  $\mu_1$  is the mean index (either for the external or for internal factors) of physicians with 0 to 5 years in the profession,  $\mu_2$  is the mean response of physicians with 6 to 10 years in the profession, etc. As previously explained, for these type of analysis of comparing the mean of more than two populations, one way ANOVA was utilised.

The analysis of the survey data is presented and examined in detail in chapter five. It includes a report of the type and size of practice surveyed, obtained from the first seven questions in the survey instrument (appendixes 1 and 2). The results of the t-test to analyse the responses of the physicians to the forty one statements were compared to the results from the research from where they were drawn. The various analysis for the variables under study are also presented in chapter five. Based on the findings of the quantitative phase of the research methodology, the context for phase three (qualitative research based on case studies) was finalised.

### **3.4.4 Phase Three: Qualitative Research**

#### **3.4.4.1 Introduction**

Phase three of the research design is an attempt to clarify the concepts that emerged from both the literature review (phase one) and the analysis of the survey (phase two) and to further evaluate the model for marketing in small professional service firms (figure 2.3) utilised as the general framework for the research. The emphasis of this phase of the research was to examine influences of key external and internal aspects of the small firm, over time, as it relates to the use (or lack of use) of marketing. The interaction between the external and internal

environment over the life cycle of the professional service practice was a priority of this phase of the research.

A series of focus groups was among the qualitative techniques considered for this phase of the research design. This technique "...usually consist of 10 to 20 people who are brought together to represent a particular population like... members of a particular profession" (Fisk, 1995b p. 21). Focus groups are an effective way of obtaining the input of several respondents at one time. The drawback, however, for this research includes the difficulty of operationalising this type of session given the unpredictable nature of physicians' schedules. Another disadvantage is the possibility of responses from physicians being adversely impacted by what other colleagues would answer or by what physicians' perceive as appropriate statements in a meeting with colleagues.

Case study analysis was believed to be, given the objectives of the research and the peculiarities of the subjects under study, a more appropriate alternative for this phase of the research design. This is so because this phase of the research wanted to gain insights into what physicians understand by marketing, why physicians agree or disagree with the use of marketing for their practice, why they undertake (or fail to undertake) marketing activities and how they go about deciding, implementing and monitoring such activities. The use of case studies in situations such as these is very well supported by Yin (1989, p. 13) who describes them as "...the preferred strategy when "how" and "why" questions are being posed, when the investigator has little control over events, and when the focus is on a contemporary phenomenon within some real-life context".

#### 3.4.4.2 Case Study

According to Yin (1981a, 1981b), a case study investigates a contemporary phenomenon within its real-life context, when the boundaries between phenomenon and context are not clearly evident and in which multiple sources of evidence are used. Schramm (1971) has argued that the essence of a case study, the central tendency among all types of case study, is that it tries to illuminate a decision or set of decisions: why they were taken, how they were implemented and with what result. In addition, according to Yin (1989), case studies have four different applications, namely:

1. to explain the causal links in real-life interventions that are too complex for the survey or experimental strategies.
2. to describe the real-life context in which an intervention has occurred.
3. an evaluation can benefit, again in a descriptive mode, from an illustrative case study - even a journalistic account - of the intervention itself.
4. the case study strategy may be used to explore those situations in which the intervention being evaluated has no clear, single set of out-comes.

The research design for the case study approach adopted here followed the components recommended by Yin (1989):

1. Study questions - the form of the question in terms of "who", "what", "where", and "why", provides an important clue regarding the most relevant research strategy to be used. The case study strategy, as previously explained, is most likely to be appropriate for "how" and "why" questions.
2. Study propositions - each proposition directs attention to something that should be examined within the scope of study. In this research, this includes what physicians understand by marketing, why physicians agree or disagree with the use of marketing for their practice, why they undertake (or fail to undertake) marketing

activities and how they go about deciding, implementing and monitoring such activities.

3. Unit of analysis - the definition of unit of analysis (and therefore the case) is related to the way the initial research questions have been defined. Also, it is related to the problem of defining what the "case" is. In the classic case study a "case" may be an individual. Sometimes the "case" can be some event or entity that is less well defined than a single individual. In this case, the available research literature presented in chapter two became a guide for defining the physician in private practice as a case and unit of analysis.
4. The logic linking the data to the propositions. This can be done any number of ways. One approach for case studies is "pattern matching" described by Campbell (1975), whereby several pieces of information from the same case may be related to some theoretical proposition. Another way is to do cross-case tabulations. This study utilised a combination of both pattern matching and cross-case tabulations, in an effort to better examine patterns of differences and similarities within each case as well as how one case relates to another.
5. The criteria for interpreting the findings. There is usually no precise pattern of setting the criteria for interpreting the findings of case studies. In this case, however, the previous two phases of the research design (literature review and analysis of the area under study - section 3.4.2- and the quantitative research via a survey of a sample of physicians - section 3.4.3) provide a framework for interpreting the findings of the case study.



marketing activity related to the model (figure 2.3) that could be selected “a priori”. Also, it was determined that there was a need to have physicians from both, primary and secondary classifications for the cases to be studied given the situation of the health reform programme under way in the region under study (which is described in chapter four). Thus, the methodology for case selection here explained was adopted.

The research by Vera (1996) assessed the regions in which the most and the least physician advertisements were placed in the 18 month period covering 1995 and the first six months of 1996. From each of these two regions, all the regional newspapers published in January and February of 1997 were reviewed to determine the physicians that advertised in the period nearest to the time when the fieldwork was undertaken. The telephone directory yellow pages, which list all physicians in a region by type of specialty (Rodríguez and Romaguera, 1997), was utilised as a master listing of physicians to determine the physicians in each of the two regions (in the various specialties) that did not advertise. This resulted in four clusters: two sets of physicians from group one - physicians that performed newspaper advertising (one from the region where most physicians advertise and one from the region where few physicians advertise); and two sets of physicians from group two - physicians that did not advertise in regional newspapers (one from the region where most physicians advertise and one from the region where the least physicians advertise). Each of these sets also divided physicians by their primary and secondary healthcare classification (table 3.2).

A random selection of two physicians that advertised from each of the two geographic regions previously explained was undertaken - one selected from those classified as primary health practitioners and one selected from those classified as secondary health practitioners. In order to maintain that variable constant, the group of physicians that did not advertise (in each of the two regions) was reduced to those that mirrored the specific primary/secondary classification of

those randomly selected from among the advertisers in each region and from that subgroup, physicians that did not advertise were randomly selected for the case study.

The resultant eight cases, as shown in table 3.2 below, resulted in four physicians from group I (those that advertised) - two from each of the geographic regions - one primary and one secondary health provider; and four physicians from group II (those that did not advertise) - two from each of the geographic regions - one primary and one secondary health care provider.

**Table 3.2: Cases Investigated**

Region	Physician Classification	GROUP I Physicians that advertised	GROUP II Physicians that did not advertise
Region 1: with most physician advertising (4 cases)	Primary Physician	Internal Medicine (case 5)	Internal Medicine (case 2)
	Secondary Physician	Ophthalmologist (case 1)	Ophthalmologist (case 4)
Region 2: with the least physician advertising (4 cases)	Primary Physician	Family Physician (case 3)	Family Physician (case 8)
	Secondary Physician	Surgeon (case 6)	Surgeon (case 7)
		4 cases	4 cases

In order to link the cases with the survey (phase two), the questionnaire (appendixes 1 and 2) was administered to all the physicians interviewed. This allows for the cases to be positioned in the context of the survey findings.

#### **3.4.4.4 Field Work - Qualitative Research**

The fieldwork was conducted from February to May, 1997 based on individual semi-structured interviews of approximately two hours' duration with the physician owner of the practice (in one case with one of the two physicians that owned the practice). The interviews were recorded to allow the researcher to review, repeatedly, the various interviews as the analysis was carried out. The "aide memoire" utilised to guide the interviews is included as appendix 4.

As the fieldwork was carried out, the researcher made notes during the interview. General notes and observations were also made after each of the interviews. These notes were analysed to learn from the particular case and to better define particular areas to inquire, if need be, as the interviews for other cases took place. This manner of conducting the fieldwork allowed for understanding each case on its own, as well as for identifying similarities, differences, and patterns of the group of cases as the fieldwork progressed. This methodology is important for obtaining the maximum benefit attributed in the nature of multiple cases that have been acknowledged as specially important as comparison groups (Glaser and Strauss, 1970). The fieldwork methodology also allows for a strategy of "replication" (Yin, 1991) where the findings of a single case are successively tested in the other cases. It is believed that the careful use of this fieldwork methodology results in powerful explanations (Eisenhardt, 1989).

#### **3.4.4.5 Case Study Analysis**

An important step in this research is the case study analysis. The primordial objective of this analysis is (1) to explain the "why" of the findings from the quantitative research, (2) to augment the findings of the literature review, (3) to determine the "how" and "why" questions of the physicians' level of agreement with marketing and how marketing actions are decided and implemented, and (4)

to describe or examine its real-life context of the physicians. Each case is studied separately to examine its particular aspects. Then, cross-case tabulations have been used to examine how one case relates to another to reveal differences or similarities and patterns in the level of agreement of physicians towards marketing their private practices, what aspects of marketing they undertake or fail to undertake and how these are planned, carried out and evaluated. The analysis of this qualitative research is presented in chapter six.

### **3.5 SUMMARY**

The research design of this study is exploratory and descriptive in nature. The purpose of this study is to examine the roles that key components of the external and internal environment of the small professional service firm have in the process of adopting (or failing to adopt) a marketing orientation. The general framework to conduct the research, based on the literature reviewed (section 2.8) is the Model for Marketing in Small Professional Service Firms (figure 2.3) which incorporates both the external and internal environment to Carson's Model for the Development of Small Firm Marketing (1985, 1990, 1993). One purpose of this study is to describe and understand the perceptions of professional service providers in smaller enterprises to marketing their practices, using physician's services in Puerto Rico as a case study. As outlined in section 3.3, the study attempts to (1) describe and examine the level of agreement that the physicians have about marketing their private practices with the intention of establishing differences and similarities between respondents; (2) determine if the physicians' level of agreement of marketing can influence their attitudes toward marketing their private practices.

To meet these objectives, the research design consists of three phases, each utilizing a methodology and instruments appropriate for the particular phase of the work. Research designs that use various

methods have been used increasingly and are viewed as particularly appropriate for research that involves marketing and entrepreneurship. This is exemplified by Kirby, 1995 (p. 23) in his review of the presentations at the 1994 Research Symposium on the Marketing/Entrepreneurship Interface "... it is not necessarily about adopting either a "quantitative" or a "qualitative" approach to the subject, but about developing a research design which is appropriate for the issue under investigation. This may involve adopting a battery of approaches and techniques...". The use of various dimensions of research, according to Fillion (1990 pp. 16-17), is deemed "complementary... in helping understand organizational phenomena. Today, the debate between qualitative and quantitative [research] has largely died down as far as management practice is concerned".

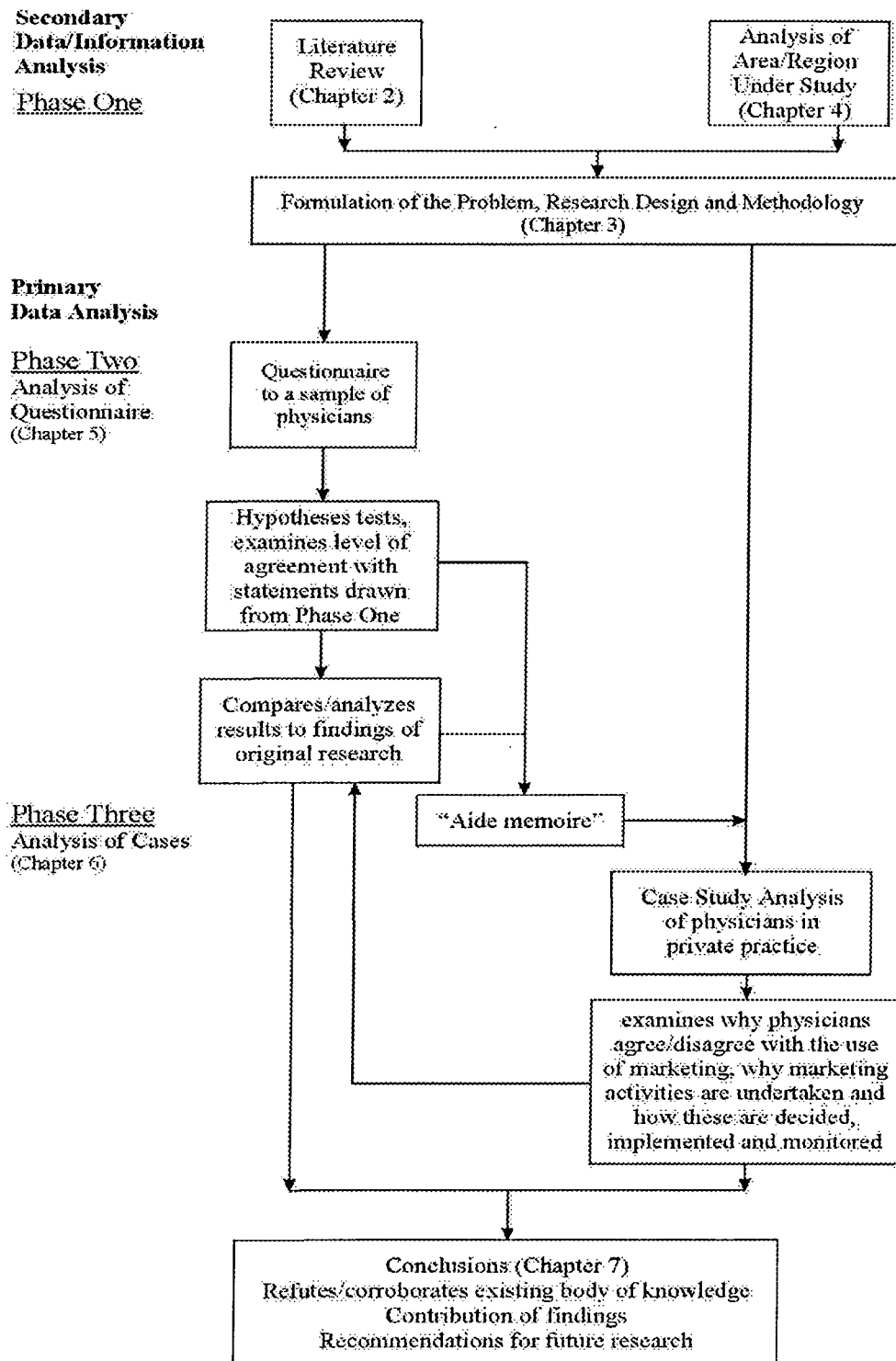
The findings of the study are compared with the existing body of knowledge on professional services and small firm marketing in order to refute/corroborate the existing body of understanding and further knowledge. The findings are used to evaluate the Model for Marketing in Small Professional Service Firms (figure 2.3) used as general framework for the research, and to propose changes, as needs be.

Figure 3.1 below summarises diagrammatically the three phases of the research design. Phase one (section 3.4.2) consists of the literature review (chapter 2) which identifies what is known and provides the theoretical context for the investigation, and an analysis of the area/region under study via secondary data (chapter 4) to understand the particulars of the industry/area where research takes place and to provide the situational context upon which to analyse the findings. Phase two is the quantitative research (section 3.4.3) by means of a questionnaire administered to a sample of physicians in Puerto Rico. This phase of the research includes testing a series of hypotheses derived from statements drawn from the literature (sections 3.4.3.2 and 3.4.3.6), which include aspects dealing with both the external and the internal environment of the professional service practice (figure 2.3). This phase of the research design

helps to set the context for qualitative research based case studies (phase three of the research-section 3.4.4). Phase three of the research design clarifies the concepts that emerged from the literature review (phase one) and the analysis of the survey (phase two) and further evaluates the model for Marketing in Small Professional Service Firms (figure 2.3) utilised as the general framework for the research.

This research relies on triangulation, described by Janesick (1994) as the use of several kinds of methods or data as a research design, and by Stake (1994, p. 241) as "...a process of using multiple perceptions to clarify meaning, verifying the repeatability of an observation or interpretation". Denzin (1978) classifies triangulation into four basic types: data triangulation (use of a variety of data sources), investigator triangulation (use of different researchers or evaluators), theory triangulation (use of multiple perspectives to interpret data), and methodological triangulation (use of multiple methods to study a particular situation). This research attempts to carry out triangulation in a variety of ways including methodological triangulation (use of literature survey, quantitative and qualitative methods), data triangulation (use of secondary and primary data sources) and investigator triangulation by means of presenting the preliminary findings of the research in papers at research symposia focused on the marketing/entrepreneurship interface to obtain feedback and evaluation from other researchers in the field.

Figure 3.1 Summary of Research Design



The preliminary findings of phase two of the research (quantitative analysis) were the basis for a paper presented in Stockholm, Sweden in June 1996 at the UIC/AMA Research Symposium on the Marketing/Entrepreneurship Interface (Romaguera and Kirby, 1996). The background for the methodology used for selecting the case studies was included in a paper presented in Dublin, Ireland in January 1997 at the Academy of Marketing/UIC/AMA special interest group symposium "The Marketing/Entrepreneurship Interface" (Rodríguez and Romaguera, 1997). The preliminary findings of phase three of the research (qualitative analysis) was the basis for a paper presented in Chicago, Illinois (U.S.A.) at the UIC/AMA Research Symposium on Marketing and Entrepreneurship (Romaguera and Kirby, 1997) which was included in the proceedings that were published a year latter (Romaguera and Kirby, 1998).



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## CHAPTER 4

### THE SITUATION IN THE REGION/AREA UNDER STUDY

#### 4.1 INTRODUCTION

For developed as well as developing countries, health care is a major concern. The pressure to provide more and better services to all citizens while reducing the fiscal impact, has been a major priority for most advanced level economies.

Industrialised nations such as the United Kingdom, Japan, Germany, France and Canada provide universal health care at a cost representing from 6.1% to 9% of the Gross Domestic Product (GDP). By contrast in 1990, the United States devoted 12.4 percent of its GDP to health care- the highest in the world, both as a share of the GDP and on a per capita basis (Organization for Economic Cooperation and Development et al. 1993). Notwithstanding this disproportionately higher spending, the United States in 1993 had a population of 37 million without health insurance, representing 14.7% of the population (significantly higher than in any other industrialised country), and an additional 25 million were without adequate coverage (Clinton, 1993). The situation is currently worst, as “the United States spends more on health care than any other country...(but) 44 million people across the country (is) without health insurance” and it is projected that “47 million people will have no insurance five years from now” (Consumer Reports, 2000 pp. 42-43).

Health care in Puerto Rico, a Commonwealth of the United States, is being affected by the wide process of evaluation that is currently being undertaken in the United States, as well as by revisions to its own health programme. Both influences (the U.S. and the Puerto Rico initiatives) are designed to increase health coverage in the population while keeping costs under control by increasing competition. This increase in competition amongst health care providers in Puerto Rico makes it an

ideal region in which to carry out the field work of this thesis. The insights gained from the research have significance for developments elsewhere, as all economies aim to make better use of resources to provide universal care.

This chapter provides an overview of health care and discusses the state of the health care system in the United States and Puerto Rico at the time the research was undertaken. The health reforms proposed and implemented, the impact these can have in shaping the new scenario under which physicians operate, and the implications for the marketing of physician services in solo practice are also presented.

#### **4.2. OVERVIEW OF HEALTH CARE**

Health care is a major concern in most parts of the world. This concern takes different forms depending on the political economy of the countries in question and their stage of development. In the developing countries, for example, an issue of concern is the supply of drugs and equipment which is restricted due to the shortage of imports resulting from the pressures these governments have to cut expenditures. This results in reduced supplies, personnel and facilities. In the transition economies, such as the Central and Eastern European countries, the problem has to do with the breakdown of the old system of health care, without an adequate replacement being yet in place. In addition, the reduction in economic activity and incomes has increased significantly the problems of providing health services for the citizens of the countries in these economies. In the developed countries, the inordinate increases in costs of health care are an unresolved problem. A similar challenge has to do with organizing health services in order to ensure their delivery is both equitable and efficient (United Nations Publications, New York, 1993). All of this makes health care a complex issue around the world.



The high cost of health care has been more accentuated in the United States than in other developed countries like the United Kingdom, Canada, Germany and Japan. "In 1990, 12% of [the United States] GNP was spent on health care" (Newhouse, 1992, pp. 3-21). In recent years, the National Health Service in the United Kingdom, for example, has experimented with changes in its organisation essentially providing for greater autonomy in the management of budgets as a way to stimulate sharper competition among providers. In Sweden, Denmark and Norway, a high proportion of the cost of health care services is paid from taxation. In Canada, the national, universal (health) insurance scheme is financed by federal and provincial governments.

Developed countries have begun to reorganise the provision of health care services in terms of quality, equity and price with the double intention of improving the health care system and providing the right health service at the right price. The thrust of these reorganisations has focused on allowing for planned competition because of the belief that "competition among health care providers has been shown to raise the quality of services and cut prices" (United Nations Publications, 1993, p. 46). The particulars in each country vary but the overall need is the same: to utilize resources more effectively to provide universal care. Such basic overall need makes the research one of considerable relevance.

#### **4.3 THE STATE OF HEALTH CARE IN THE UNITED STATES**

At the time the research was designed, health care in the United States was undergoing a wide process of evaluation that continues to date. The issue of whether or not health care needs restructuring has given way to a debate on how this might be achieved. The main issues, according to the literature, are how to achieve complete coverage of the population, and how to control the rising costs of health care, already relatively higher than in other industrialized economies and when

compared to the other areas of spending within the country itself. This is best exemplified, perhaps, by the following quotation:

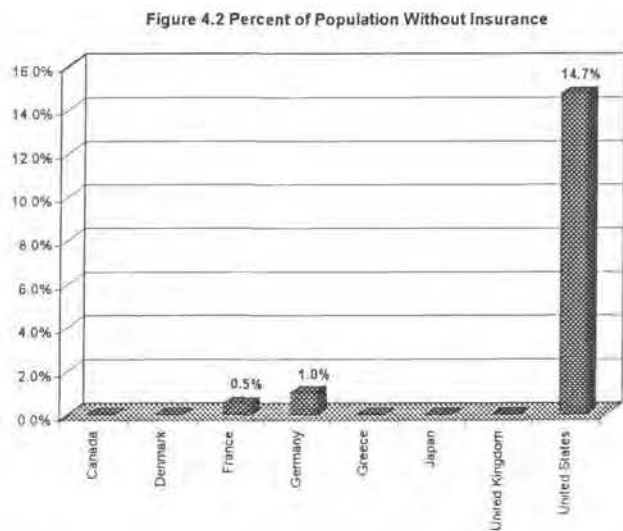
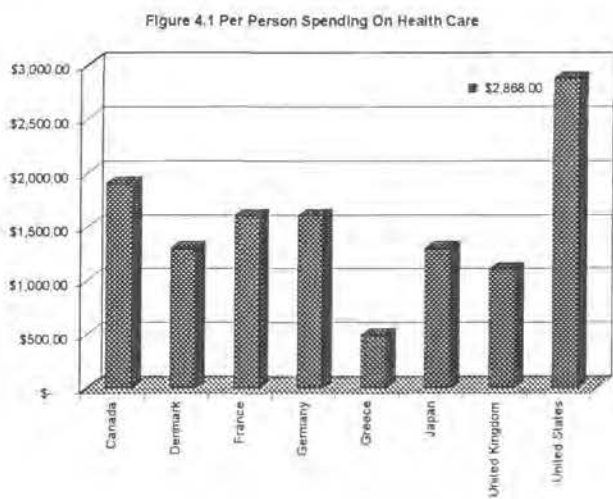
*"We cannot - indeed, we dare not - attempt to cross the threshold of the 21st Century without fundamentally restructuring our health-care system. Too many citizens (37 million) in this country are without health insurance and hence have no access to health care except in emergencies. Health care costs in many areas of our society are out of control. Furthermore, measured by international statistics, the health-care delivery system does not perform as well as we would hope." (White, 1993a, p. 2).*

The situation is that health expenditures in the United States are the highest in the world, both as a share of the GDP and on a per capita basis. "In 1987, United States per capita spending on health care was \$2,051.00, representing 11.2 percent of the GDP" (Hughes et al. 1991, p. 1-2). In 1992 health expenditures were up to 14 percent of GDP (The White House Domestic Policy Council, 1993 p. 7) and has continued at that level with predictions it can reach nearly 20 percent by the year 2005 (Licking 2000).

This contrasts markedly with other industrialised nations. As Hughes et al. (1991, p. 12) have demonstrated: "... between 1970 and 1980, the growth rate of health care expenditures in the United States exceeded the rate in Germany, France, Canada, and the United Kingdom. Since 1980, health expenditures have remained a relatively constant eight percent in Germany, France and Canada, while they have continued to rise in the United States. In the United Kingdom, health care expenditures are even lower than other major developed countries". In 1990 the United States devoted 12.4 percent of its GDP to health care, "about twice the proportion Britain spends on the National Health Service available to everyone... (while the United States health care system) still leaves at least 33 million people with little or no coverage" Barr (1993, p. 22). That year, according

to the Organization of Economic Cooperation and Development, Japan's universal health plan represented 6.7 percent of the country's GDP, Germany spent about 8 percent, while 9 percent was spent by Canada and France to provide universal care (Barr, 1993).

As figure 4.1 shows, the United States spends more per person in health care than other developed countries. Notwithstanding such disproportionately spending, close to 15 percent of its population is without health insurance (figure 4.2), whereas virtually all of the population in the other developed economies enjoy the benefits of universal health programs.



Source for figure 4.1 and 4.2: Organization of Economic Cooperation and Development; Department of Health and Human Resources as reported by the White House Domestic Policy Council, 1993, p. 11.

In summary, the United States' health care system compares less favorably with those of other industrialised countries in terms of cost per capita and as a percentage of GDP, a trend that has grown in the last two decades. The health systems in the other countries provide universal coverage (which is currently lacking in the United States) and the life expectancy for men and women in all cases (except for women in the United Kingdom) is higher in the other industrialised countries (table 4.1).

Table 4.1

Comparison of International Health Care Systems

		United States	Canada	France	Germany	Japan	U. K.
Health spending per capita	1970	\$346	\$274	\$192	\$199	\$126	\$144
	1990	2,566	1,795	1,379	1,287	1,113	909
Health spending as percent of GDP		12.4%	9.0	8.9	8.1	6.5	6.1
Number of doctors per 1,000 population		234	215	250	281	157	137
Life expectancy	Men	71.5	73.0	72.3	71.8	75.5	72.4
	Women	78.3	80.2	81.6	78.4	82.3	78.1

Source: Organization for Economic Cooperation and Development, AFL-CIO, WHO as reported by Associated Press in the San Juan Star, September 20, 1993, page 11.

When the 12.4 percent of GNP health care cost in 1990 in the United States (Barr, 1993) is compared with the percent of GNP cost in the same year for education and defence, it is clear that more was spent on health-care than on education and defence together - a gap that has widened each year since the early 1970s (Statistical Abstract, 1992, tables 525, 135 as reported by the White House Domestic Policy Council, 1993 p. 8). In addition to the share of GDP and how it compares to other items of national interest, the rate of increase in health care spending is a source of alarm. "Health-care spending grew by 11.5 percent ... (in 1992) - nearly four times the general rate of inflation (in the United States)" (Deets, 1993, p. 30). More recently, the United States spent 13.7 percent of its GDP on health care (with 44 million Americans without health care insurance) while

the other industrialised nations spend less of their GDP in health care and provided coverage for all their citizens. France and Germany, for example spend 9.8 percent and 10.5 percent of their respective GDPs to provide effective health coverage to all their population (Karpatkin, 2000). According to the statistical Abstract, 1988, table 716 (as reported by Anderson and Vincze 2000) health services continues to represent the highest level of expenditures for all services in the United States (376.6 billions of real 1992 dollars in 1996). Notwithstanding its size, health care in the United States and Puerto Rico is a very fragmented industry, as explained by Licking 2000:

*"Health care is the modern-day equivalent of a medieval patchwork of fiefdoms, with doctors, hospitals, and insurance companies allied to form local—not national—power structures. ...It is an industry populated by entrepreneur-physicians and clinicians who are trying to break even in what has become a high-volume, low-margin business... this whole composite of fragmented cottage industries in under crippling financial pressure as medical spending continues to skyrocket" (Licking, 2000, p. EB 62).*

The scenario described in this section provides an overall frame of reference to understand the background of the area/region under study at the time the research was designed and undertaken. The particular initiatives explored and undertaken in the United States (section 4.4) and Puerto Rico (section 4.5) to address the situation provide a frame of reference for analysing the results of the quantitative and qualitative surveys (chapters 5 and 6, respectively).

#### **4.4 HEALTH SECURITY- PRESIDENT CLINTON'S HEALTH REFORM PLAN**

Health-care reform was one of the most debated issues in the United States' 1992 Presidential Campaign. During President Clinton's first year of office (1993), the "final" reform package took shape and was formally presented to the United States Congress in September, 1993 as the Health Security Act. In his address to the Joint Session of Congress on September 22, 1993 the President is

quoted as saying: "Our competitiveness, our whole economy, the integrity of the way the government works and ultimately, our living standards depend upon our ability to achieve savings without harming the quality of health care".

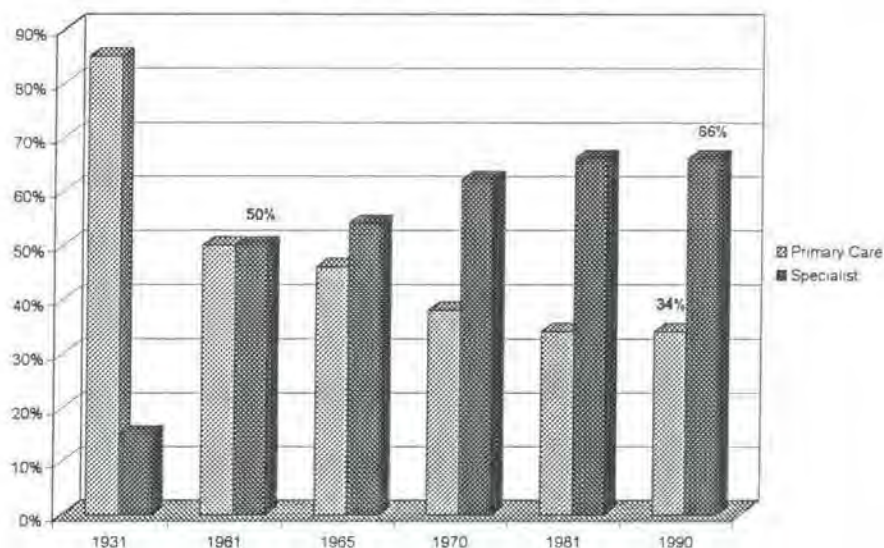
At that time, the act was described as "... *the boldest, most expensive social initiative since the New Deal, bigger even than F. D. R's (President Franklin D. Roosevelt) institution of Social Security (the universal retirement plan) half a century ago. It would intimately affect the health and livelihood of every American...*" (Goodgame, 1993, p. 54).

The political battle surrounding the legislation for the Health Security Act "...forced (President Clinton) to abandon that crusade in a debate that dimmed his popularity and expelled his wife Hillary from health care reform..." (Schoene-Roura, 1996, p. 52). The Health Security Act presented by the President of the United States proposed a series of principles and various key concerns that need to be reviewed in order to understand how it intended to change the system of health delivery. Even though the legislation per se did not prosper, the principles under which it was based have served as an agenda, a frame of reference, for service providers, health insurers, and political leaders for most of the 1990s and has contributed in shaping physicians' attitude towards health reform. Thus it is probable, that the responses of the physicians surveyed (chapters 5 and 6) have been impacted, in some degree, by such developments in the external environment.

Appendix 5 provides a note on the Health Security Act which summarises various key aspects of the proposed legislation. Among the aspects that need to be understood is the issue of increasing competition in the health services marketplace as a manner of controlling costs. The issue is best described by Morgenthau (1993, p. 32) who states that the approach to health-care reform by President Clinton "...would dramatically affect 630,000 American doctors and 3 million other health professionals, and it would radically restructure an industry that is bigger, in dollar value, than the

entire Italian economy ." To understand the dramatic effect of the health reform on doctors, it is important to appreciate the change of composition of doctors as specialists vis-a-vis primary care physicians.

Figure 4.3 Doctors in the United States



Source: Council on Graduate Medical Education, October 1992,  
As reported in the White House Domestic Policy Council, 1993, p. 68.

As Figure 4.3 shows, in 1931 over 85% of Doctors in the United States were primary care physicians while specialists comprised a minority. This situation shifted dramatically in recent decades resulting in a majority of Doctors as specialists (66%) in 1990 vis-a-vis primary care physicians (34%).

The net effect of the built-in strategy of increasing competition in health care described above, leads to the projection that "the plan ... would push Americans away from private doctors and into less expensive group, medical practices such as health maintenance organizations (HMO's). It would hold down the income of many doctors, hospitals, insurers and drug manufacturers through stringent federal costs controls" (Goodgame, 1993, p. 54). The "... emphasis on HMO's would sharply increase demand for the general practitioners who staff them. That means fewer plots for specialists" (Morganthau, 1993, p. 32). The new plan places emphasis on preventive and primary care thus

putting an emphasis on family physicians, general internists and pediatricians - the principal primary care practitioners among physicians (the White House Domestic Policy Council 1993, p. 66). In the long run, this could shift the pendulum back and reverse the trend that led to a 66% of specialists vis-a-vis a 34% of primary care physicians in 1990 in the United States (Figure 4.3). The early signs of the impact of the efforts to reduce health care costs were reported in 1996 (Winslow, 1996) with the release of the survey of the economic trends undertaken by the American Medical Association (AMA). The study revealed that Doctors' average pay fell 4% in 1994, the second time in which average physician income fell since the AMA began collecting such data in 1982. Doctors at the upper end of the income scale experienced a 6% income reduction while general practitioners and family doctors reported a modest rise in earnings. This shift in income was attributed, according to the study (Winslow, 1996) to the increase of managed care. Likewise, "physicians (that) work in small practices outfitted with one or two doctors...took a big hit in 1997, when the Balanced Budget Amendment pared back already slim reimbursements from HMOs and Medicare" (Licking, 2000, p. EB 62).

In an attempt to force change to more general practitioners and fewer specialists, the Clinton plan proposed to empower the federal government to decide the number of doctors to be trained each year in the various specialties. "Clinton will also propose vastly expanding the roles of nurses, nurse practitioners, physician assistants, midwives, social workers and other health-care professionals who do not have M. D. degrees" (Pear, 1993). All of this, again, increases the competition for physicians, particularly specialists. Early signs of the changes this brings about is the 1995 research (Burghart, 1996) that found that the demand for general practitioners was catching up to the demand for specialists in 1995 vis-a-vis 1990, as evidenced by research that studied recruitment advertisements in medical journals.



The emphasis in the Health Security Act on controlling costs and providing access to all Americans by "... enlisting the power of a competitive market and empowering consumers to make choices that suit their needs" (Government Printing Office, 1993, p. 14) would result in a potentially larger market for physicians by extending coverage to the 37 million Americans not covered by medical insurance. Also, those currently covered by plans for which their employers originally made the choice, would be in a position to choose for themselves. The fact that consumers would receive performance reports on health plans on an annual basis and can change plans every year if not satisfied with the service received, provides for more information and choice than at present and deliberately pushes for competition among possible health plan providers and at the consumer level. This proposed increase in competition forces a more customer oriented focus on the part of the service provider, particularly given the customer's ability to choose among options in selecting a plan and to choose between specific physicians, not withstanding the plan selected.

The specialist would be in an environment of less demand both by the plans themselves and by final consumers, the opposite being true for the primary care physicians. As a result, the price for the services of specialized physicians could come down or stabilise. In an effort to minimise the price (cost) aspect of physician services perhaps a greater emphasis will need to be placed by physicians on the other marketing mix variables, including the service itself, which, as explained in chapter 2, is based to a great extent on the interaction of the physician with the patient. This could give way to a greater emphasis on the patient - doctor relationship, a statement already alluded to in United States Government Document: "The Health Security plan guarantees consumers a choice of health plans and enhances the patient-doctor relationship" (U. S. Government Printing Office, 1993, p. 5).

The Health Security Act proposed by President Clinton was not successful in the United States Congress. The focus on health care reform, nevertheless, resulted in improvements in health care policy including the Health Insurance Reform Act, the Family and Medical Leave Act, and

improvements to both Medicare and Medicaid programmes (Hair, 1996). President Clinton also established a consumer "bill of rights" for Americans enrolled in federal government health-care programs via executive order (Sobieraj, 1998). More recently the issue of a "bill of rights" for all patients continues to be debated by the new administration of President Bush (Meckler, 2001).

The issue over health policy in the United States has continued and was highly debated during the election campaign of 2000 by all presidential candidates. Appendix 6 presents an editorial from the New York Times News Service (2000) which highlights the continuing issues regarding health policy, and summarizes the proposals by the two major contenders for the United States presidency at the time. The editorial also voices the position of the newspaper in regards to the issue: *"though it is unconscionable that the richest country in the world refuses to cover the insurance needs of all its residents, neither candidate proposes to do much about the problem anytime soon. If this moment of economic prosperity and looming budget surpluses is the wrong one for an aggressive move toward universal health insurance, when will it be right?"* (New York Times News Service, 2000 p. 27).

#### 4.5 THE SITUATION OF PUERTO RICO

As in the United States, the area of health reform was a major issue of the 1992 Puerto Rico election for Governor that continues to date. Then Candidate Pedro Roselló, a physician himself, proposed what was described as the "... health plans (that) entail the most radical changes among the three gubernatorial candidates ..." (Suarez, 1992). After the election, and the inauguration of the Governor in early January, 1993, this campaign promise has been constantly in the news as the process of debating how best to implement health care reform in Puerto Rico has continued to take place.

Health care reform has been a major concern in Puerto Rico for decades as evidenced by the research of the needs and aspirations of Puerto Ricans (Nieves-Falcón, 1970). The research revealed that medical services and the need for medical care were ranked as the fourth problem of importance, out of a list of 20, after drugs, unemployment and crime. The problem of lack of medical services, nevertheless, was ranked by the population as the one receiving less attention from the government.

Several years later, in January 1973, the Governor of Puerto Rico approved a joint resolution of the Puerto Rico legislature creating the Universal Health Insurance Commission. The task of the Commission included studying the possibility of establishing a universal health insurance programme in Puerto Rico. The statement of purpose of the resolution (page 1) clearly establishes the scenario in the area under study at the time: "only a fraction of your population [Puerto Rico] has the opportunity " of obtaining the best health care possible, while "two thirds [of the population] depends on government health services which can not be considered fully satisfactory". To study the situation the Governor appointed a blue ribbon commission whose report (Aponte et al., 1974) includes a survey of physicians in Puerto Rico. Several statements from the 1974 survey were included in the survey instrument of the current survey (appendixes 1 and 2). The findings of this research are compared and analysed in chapter 5 (section 5.2.3.6) vis-a-vis the results of the 1974 survey.

At the time this research was designed Puerto Rico was described as having "... dual health systems: a \$1.5 billion private one for people who can afford their own medical plans and a \$900 million public health system for those who can't" (Ortiz, 1993a). The Health Department provides services for approximately 60 percent of the island's population of 3.5 million while the private sector covers the remaining 40 percent. "The objective of the reform is to take the 900 million (dollars) that now goes into the running of a government health system and using the funds to establish an insurance fund that would enable the island's 1.6 million medically indigent individuals to obtain good medical

care" (Suarez, 1993). This in essence will be done by changing the role of the government "from that of being a provider of health care services to that of contractor of health care. Changes would be in the primary, secondary and third levels of health care with new emphasis by the government on prevention and nursing of the aged and leaving medical treatment to the private enterprise" (Matos, 1993). The intent of the plan was to be implemented one region at a time taking an estimated eight years to cover the entire island (Ortiz, 1993b) if the island was not included as part of the United States National Health Security Act. Otherwise the estimate is that it could be fully operational in three years (Ortiz, 1993c).

On August 23, 1993 Governor Roselló submitted the health reform plan for Puerto Rico to a joint session of the Puerto Rico legislature one month before President Clinton presented the National Health Reform Act in Washington, D. C. The Puerto Rico bill creates a public corporation, the Puerto Rico Health Insurance Administration, "that will purchase medical insurance from private companies for the island's medically indigent" (García, 1993a). The new institution "... would pave the way for the implementation in Puerto Rico of President Clinton's health reform" according to Governor Roselló (Medina, 1993 p. 3) and as a consequence "Puerto Rico, along with about a half-dozen of the 50 states, stands at the forefront, in the vanguard of the nation's health care reform movement" (Ortiz, 1993d, p. 8). Since the United States national Health Security Act was not approved by the United States Congress, the health reform programme in Puerto Rico has been based entirely on the Commonwealth's own efforts.

On a pilot phase, the eastern geographic area in Puerto Rico started to operate in early 1994 and other regions followed from 1995 to 1998. The Health Reform was implemented in the majority of the municipalities by early 1998. The remaining municipalities, those with the largest populations, came under the Health Reform mostly during late 1998 and 1999. By July 2000, given the inclusion of all municipalities in the Health Reform, it was estimated that "99.7 percent of all residents (in

Puerto Rico) will be covered by some form of health insurance, either through the local government, Medicare, or private insurance..." (Donaldson, 2000 p. 6). Studies paid by the government of Puerto Rico state that "most users view the (Health Reform) program favorably...(with) a positive rating of 88.3 percent for the new system which will lead to the privatization of the public health service" (The San Juan Star, 1999, p. 8). Further studies, also financed by the government, "...reported that health reform has generated more than 9,000 health care jobs islandwide... (and) an increase in pharmacy sales...(of) 46 percent between 1994 and 1999" (Fajardo 2000, p. 10). As could be expected, the results reported by the government financed studies were questioned as part of the electoral process that took place in Puerto Rico, leading to the election of a new Governor in November 2000.

The Health Reform Programme "... works by granting those eligible an insurance card that will enable them to select any doctor, hospital or medical facility of their choice" (Ortiz, 1993e, p. 6). This element of choice, together with the influx of new insured customers, adds to the competitive situation in the market. This competitive situation is best exemplified by the following:

*"Puerto Rico has 181 physicians per 100,000 people, a rate comparable to the United States, Germany and other well developed nations. The problem is that 70 percent of the doctors work in the private sector, which only serves 50 percent of the population. This leads to an oversupply of doctors in the sector. Meanwhile, the number of doctors annually increases at twice the rate of new insured patients in the private sector" (Marino, 1993a).*

A brief profile of physicians in Puerto Rico is presented in appendix 7 and their distribution by geographic region and work sector is included in appendix 8. As in the United States (section 4.4), primary care physicians in Puerto Rico comprise approximately 30 percent of all Doctors while approximately 70 percent are specialists (Marino, 1993b). Competition among specialists is likely to

increase significantly as the health plan in Puerto Rico becomes effective throughout the Island with a mission of increasing access while controlling costs, mainly by promoting the utilization of primary physicians under whose referral specialists can be visited. In fact "specialists can only be visited after the primary doctor has made a referral" (García, 1993b, p. 5). After seven years of operating the Health Reform Programme the changes it brought about in the external environment have an impact on the patients, the physicians, the health insurers, and other players that make up the health care system. These impacts are best explained by Llorens-Vélez (2000): *"Governor Rosello's health plan for the needy has been praised in polls of beneficiaries, but there are still economic problems between providers and insurance companies. One main complaint among health providers is that the capitation rate they get from insurance companies does not cover laboratory, pharmacy and other services. The capitation rate is a fixed monthly sum for each patient given to health providers. Primary-care doctors are sometimes reluctant to refer patients to specialists, because they can lose capitation money which affects services. Health-care providers complain they, not the insurance companies, are assuming the higher share of risks..."* (Llorens-Vélez 2000, p. 6)

Currently, after the November 2000 election resulted in a change of the political party governing Puerto Rico, the new government is focused on bringing down the costs of the Health Reform Programme. As reported by Fajardo (2001, p. 5) the priority of the newly appointed Secretary of Health *"is to get the health reform finances under control and restore the Health Department's finances. In its seven years of existence, health reform has rung up a long-term debt of \$831.7 million, and its deficit in fiscal year 2000, which ended June 30, was \$30.7 million. The Calderón administration is projecting a deficit of \$82 million for the current fiscal year."*

Thus, the pressure on cost containment in health services (part of the external environment in which medical practices in the region/area under study operate) appears to further increase and could have an impact on physician practices.

As the Health Reform Programme emerged, so has the emphasis on the export of services as part of Puerto Rico's new economic development model. The specialists' services are part of the *"... great expectations for the health-service sector as a potential export. Puerto Rico has one of the highest ratios of doctors per capita in the world. In 1950, there was one doctor for every 1,108 habitants; in 1993, the ratio became one physician for every 300 people... this extremely high concentration of doctors has forced them to specialize, a service in which we could find a niche in Latin America and the rest of the Caribbean"* (Montano, 1994, p. 17).

This export possibility will be met with other forms of competition emerging from the technological changes that make them possible. For example, VideoMed Corporation of Miami, Florida, positions itself as "comprehensive health care delivery through video telecommunications" and plans to target Latin America to provide medical expertise from Florida for diagnosis and consultation with patients in Latin America via telecommunications. This is not new. It was used in Alaska some 30 years ago as a means of providing specialised health care to isolated communities and more recently in 1993 to do the same in areas of Florida (Sasmor, 1994) and in Georgia (Bair, 1993). More recently, Kaiser-Permanente (the largest HMO in the United States) offers a Web site that allows patients to register for office visits and send questions to nurses and pharmacists via e-mail. The Kaiser-Permanente HMO also plans to provide its patient with online access to laboratory results and pharmaceutical refills (Green, 1998). Recognizing the changing technology, Puerto Rico created a law to regulate telemedicine "which recognizes the practice as an adequate medium through which a person can receive high-quality medical services" (The San Juan Star, 2000 p. 24). The improvements in technology make "telemedicine" possible and credible with the launch of entities like Medtel which permits well known Houston surgeon Dr. Michael E. DeBakey and Raytheon Co. "... to deliver state-of-the-art medical consultation from the Texas Medical Center... to remote areas around the world... (this will extend) electronically the superior technology and experience of U.S. centers of excellence to even the most remote regions for treatment and training" (Bair, 1993). How soon this could

happen and for what type of medical consultations it will be most suited or used ultimately by patients, is perhaps too early to tell. The point to be made is that competition in the area of physician services, general practitioners and specialists alike, could continue to increase in the immediate future as the various health reform initiatives in the United States and Puerto Rico unfold. In the long run this situation in the external environment will increase as technology makes feasible the expansion of a medical practice to all areas of the world.

#### **4.6 COMPETITIVE SITUATION FOR THE SMALL BUSINESS HEALTH SERVICES PROVIDER**

The political relationship of Puerto Rico with the United States extends to the Island the legal and regulatory aspects of business, communications, and small business financing and assistance programs enjoyed by the fifty states. Thus, the disputes and resolutions from the United States Supreme Court, the Federal Trade Commission (FTC), the United States Department of Commerce and the United States Small Business Administration, among others, shape the environment under which enterprises in Puerto Rico operate. This section provides a brief background of the most relevant regulatory issues that have taken place in recent decades in regards to marketing of health services and how the growth of small business dominated service industries has resulted in the growing competitive environment upon which health service enterprises operate.

The chronology of events leading to the marketing of Puerto Rico based services (Marks and Ahuja, 1983) includes a 1975 U. S. Supreme Court decision that cleared the way for the advertising of prescription drug prices by pharmacists; a 1977 Federal Trade Commission (FTC) prohibits states and professional groups from banning advertisements for eyeglasses, contact lenses, and eye examinations; and a 1978 FTC ruling that the code of ethics of the American Medical Association (AMA) illegally restrained competition among doctors by preventing them from advertising. The latter was appealed against by the AMA when the decision was upheld in March, 1982.



The 1977 ruling allowing advertisements for eye glasses, contact lenses and eye examinations, which preceded the 1978 FTC ruling leading to the 1982 legal resolution of the issue of allowing doctors to advertise, provided an early start for optometrists to advertise (vis-a-vis ophthalmologists). This appears to be true of other medically related professions:

*"Medically related professions such as optometry and dentistry have in some cases aggressively adopted marketing and advertising policies"*

*(Kotler and Clarke, 1987, p. 21).*

The "aggressive" adoption of marketing and advertising in optometry should have an impact on the competitive services it shares with ophthalmologists and should also have an impact on the image the latter have of marketing and its effects as well as their acceptance or condemnation of it. The fury this evokes is distilled in the two editorials that appeared in Ophthalmic Surgery in late 1980 and early 1981. In the first entitled "The Buccaneer Eye Surgeon" (Weinstein 1980, p. 831) it is observed that "... the printed and electronic media have been the means for introducing information ... not only to the public at large, but to the medical profession" as the medium used by the "buccaneer" physicians to "... become wealthy, unashamedly advertising their high-priced services to attract the gullible consumer, the patient". These physicians are referred to as "... the shame of ophthalmology" and in a clear reference to the legal issues and in defiance of the resolutions of the Federal Trade Commission discussed previously, the editorial concludes:

*"Let us not remain silent about them. Our society has made the task more difficult by tying the hands of medical societies and state licensure boards with "restraint of trade" regulations and legal precedents. But no one, not the Federal Trade Commission nor the attorneys who are so readily available to represent all forms of scoundrels, need tell us what we know to be true: The ethics of the medical profession are based on the interest of the patient, not those*

*of the physician. The buccaneer eye surgeons are not our folk heroes: They should be exposed to the public for what they are" (Weinstein 1980, p. 831).*

The expressions in the editorial of Ophthalmic Surgery appear to be shared by many physicians, judging from the many who responded expressing agreement with it. This fueled a second editorial on the issue ("The Buccaneer Eye Surgeon: Part II) where Weinstein (1981, p. 17) explains that in their twelve years of publication "...never has there been a response from our readers like the one that followed the editorial..." As a way to attempt to deal with these physician "buccaneers" it was suggested that "...we (ophthalmologists) ought to make efforts to exclude these individuals from prestigious meetings and journals. This would remove the stamp of respectability that many carry as speakers and authors". The editorial concludes by saying:

*"Medicine is often accused of being an elite profession. So be it. Let us take the first step to rid ourselves of those who are not worthy to be called our peers" (Weinstein 1981, p. 171).*

Both of these editorials deal with marketing and advertising, described as an act of their unscrupulous "peers" that has become more business oriented (in the most negative of sense). This is also implicit in other literature, and summarised by Margo (1986, p. 1575):

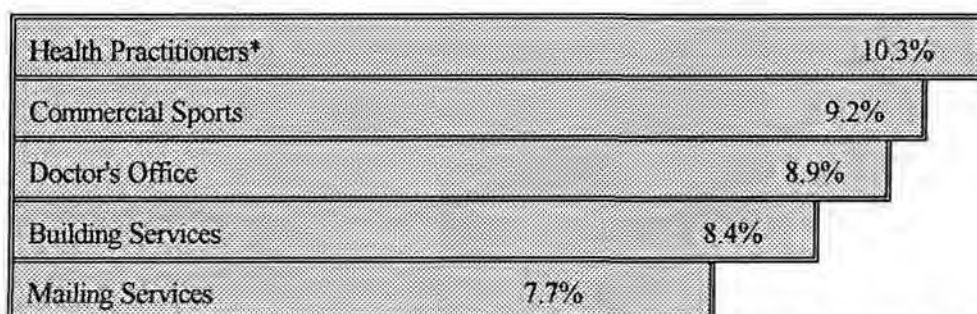
*"There is reason to believe that the overall effect of advertising by ophthalmologists may be detrimental not only to the public, but also to the specialty itself. Ophthalmology encompasses both medical and surgical practice. It is the disparity in monetary rewards between these two areas that can be exploited by the successful businessman. Advertisements in the field of ophthalmology are almost exclusively designed to promote surgery."*

The growth and competitive situation of service firms in the U. S. and Puerto Rico economy, particularly among Doctors' offices and "other health practitioners" in the late 1980s to the early 1990s, sets the stage for more marketing of health services. As the legal resolution of the issue of marketing is over two decades old, marketing today, presumably, is more widely practised and "accepted" among the medical profession than before.

Receipts of firms in the service sector (including those in Puerto Rico) are analysed in the 1990 Service Annual Survey prepared by the U. S. Department of Commerce. This reveals that "In terms of sheer magnitude, the larger receipts in 1990 were recorded in the offices of physicians (\$111.9 billion)... Contrary to many suppositions, the data illustrate that the largest receipts in the service sector are concentrated in knowledge - intensive and capital intensive industries, rather than the more labour - intensive personal service sectors" (The Small Business Advocate, 1992, p. 8).

Figure 4.4

Small-Business-Dominated Service Industries with the Biggest Growth in Receipts, 1984-1990 (Percent)



Source: U. S. Department of Commerce, Bureau of the Census, Service Annual Survey (Washington, D. C. U.S. Government Printing Office, 1991), as reported in the Small Business Advocate, 1992, p.8)

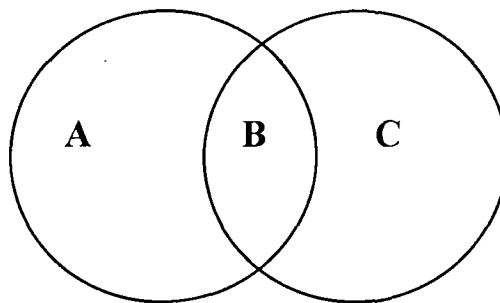
\*Note : "Other Health Practitioners includes podiatrists, chiropractors, and optometrists.

In terms of growth among small business dominated services industries, as Figure 4.4 shows, Health Practitioners experienced the biggest growth on a percentage basis from 1984-1990 and Doctors' offices ranked third in growth amongst small-business-dominated service industries. While the

growth of "other health practitioners" might lead to more competition amongst themselves (ie. optometrist versus another optometrist) and the growth of "Doctor's offices" might lead to more competition amongst themselves (ie. one ophthalmologist versus another ophthalmologist), the fact that both are growing substantially can further lead to another level of competition: that where the service offerings of both interface. Figure 4.5 below depicts this situation.

Figure 4.5

Competition at the Interface of Health Professional Service Providers  
**OPTOMETRIST      OPHTHALMOLOGIST**



- |            |  |
|------------|--|
| Service A: | mostly performed by optometrists (ie. routine eye examinations)  |
| Service B: | can be performed by both (ie. eye examinations, prescribe and prepare eye glasses and contact lenses). |
| Service C: | performed by ophthalmologists (ie. surgery, lens implants, etc.).                                      |

These various types of competition, at a time where the marketing of services in general has come of age and the obstacles for the marketing of health services have been legally resolved, make fertile ground for the development of marketing of the professional practice in the small business dominated service industries.

That scenario in the region under study encompasses the realities of the core need to attract and retain customers (patients) explained in chapter two. The emerging service practices (other health services and/or Doctor's office), certainly as they initiate operations, need to attract patients. Some will be patients requiring certain services for the first time while others could be patients receiving medical services from other providers. The latter could be the target of their current service providers for

retaining them as patients. Conversely, as current providers lose patients for whatever reason (eg. need for medical services has been taken care of, the patient quits treatment, or the patient goes for service to other provider(s) they could target other than their current patients (those being serviced by other providers and/or those not receiving attention yet) in order to have them as clients.

This illustration merely shows the nature of how attracting and retaining patients, particularly as the rate of providers grows faster than the rate of potential patients, allows for an increase in competitive pressures. This requires a focus on the customer - a marketing orientation - because "as the pace of competition speeds up, it is imperative to know first hand how needs and expectations are changing" (Boughton and Katz, 1993, p. 111). The relative size of the service providers that could be competing for these patients (eg. group practice, defined as two physicians to 300 or 400 physicians versus solo practitioners), among others, can result in a disparity of resources and type of strategies available for implementation of one service provider versus another. This is brought forward by Cravens and Hills (1989, p. 37-42) as they describe the "*situational advantage of an emerging organization*." One of these situational advantages is described as:

*Competitive Advantage.* *Competitive advantage is a relative concept since it depends on how well an organization meets its buyers' needs and by how much its customer satisfaction levels exceed those of its key competitors. Sources of advantage may be due to superior skills and/or resources (Day and Wensley 1988). Superior skills and resources are used to gain customer and cost positional advantages which enhances the performance of the organization. (Cravens and Hills, 1989, p. 38).*

In the case of the larger medical service provider, whether or not others act as "part-time" marketers, a more formal, traditional "full time" marketer function is an option, just as some physicians will be

more involved in providing patient services while other(s) could be looking after the management and administrative functions.

The major overhaul of the health system to taking place in the United States and in Puerto Rico, as explained earlier, impacts significantly on the coverage for health assistance to the citizens in the country. The strategies for cost containment contained in the reform have an impact, without precedent, on how the professional practice shapes. All of this could accelerate the need for physicians both in solo or group practice to be customer oriented, indeed marketing oriented, to attract and retain patients. This will further increase the competition previously alluded to at a time when customers, as a result of the proposed reform, will be in a position to effect considerably more choice than in the past.

#### **4.7 SUMMARY**

A major priority for most advanced level economies is to provide more and better health care to all citizens while reducing the fiscal impact of such efforts. That is also the situation of Puerto Rico, the area under study, which is being impacted by the process of evaluation that is currently being undertaken in the United States as well as by its own health reform programme underway. Both influences (the U.S. and the Puerto Rico initiatives) are designed with an emphasis on increasing health coverage in the population while keeping costs under check via the increase of built-in competition. This increase in competition amongst health care providers in Puerto Rico makes health care an important sector and Puerto Rico an important region upon which to carry out the field work of this thesis.

Physicians' practices in Puerto Rico have been exposed to a series of significant changes in the external environment. The changes included the removal of legal restrictions that prevented the use

of certain marketing activities, and an increase in competition. The changes in the health industry, fueled by health reform initiatives, dramatically changed in a relatively short period of time the external environment upon which these service providers operate. Such dramatic changes in the external environment place a tremendous burden on the service provider that owns and manages a practice, forcing him/her to consider actions that in turn impact on the internal environment of the practice.

The insights gained from the research have significance for developments elsewhere as all economies aim to make better use of resources to provide universal care. The impact of the external and internal environment in the smaller professional service practice, particularly as it is dramatically impacted by changes in the market place, is a particular contribution of the research that has relevance for similar developments taking place elsewhere in various service industries.

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## CHAPTER 5

### ANALYSIS OF THE QUESTIONNAIRE

#### 5.1 INTRODUCTION

As outlined in chapter 3, in phase two of the research forty one specific statements drawn from the literature were formulated into a questionnaire (appendixes 1 and 2) used as the survey instrument. Physicians were asked to indicate whether they were in agreement, disagreement, or neutral with respect to for each of the statements using a five point Likert type scale. Classification data was also included in the form of several open-ended questions.

A total of 169 physicians was surveyed in Puerto Rico on September 10, 1995 at the assembly held for the Puerto Rico College of Physicians and Surgeons. A total of 105 questionnaires was used in the analysis reported in this chapter as the data on 64 of the questionnaires was lost in the aftermath of Hurricane Georges. The questionnaire was completed in the registration area immediately prior to the assembly. Approximately 15% (1,200) of the 8,000 physicians registered in Puerto Rico were in attendance and the total interviewed represents approximately 14% of all in attendance at the assembly (ie. 2.1% of the total population). As explained in section 3.4.3.4, the physicians that attended this assembly are unlikely to be representative of the total population and a convenience sample such as this is likely to be biased. However, as tables 5.1 and 5.2 demonstrate, the resultant sample does show similarities with the total distribution with respect to gender and location. Unfortunately detailed data from earlier research (Aponte et al. 1974 and the Government statistics, 1993) is not available, thus a reliable statistical analysis to measure the variance was not possible. Although the percentage distribution of this research is numerically similar to those of previous research (table 5.1 and table 5.2), the absence of a statistical variance analysis means that it is not possible to conclude whether there are significant statistical differences amongst the values.

Table 5.1 shows that the distribution in the sample surveyed in terms of gender is similar to that of all registered physicians in Puerto Rico.

Table 5.1: Sample Distribution (Gender) vis-a-vis Government Statistics

<u>Gender</u>	<u>Study 1995</u>	<u>Physician Population Government Statistics 1993</u>
Female	24.8%	23.6%
Male	75.2%	76.4%

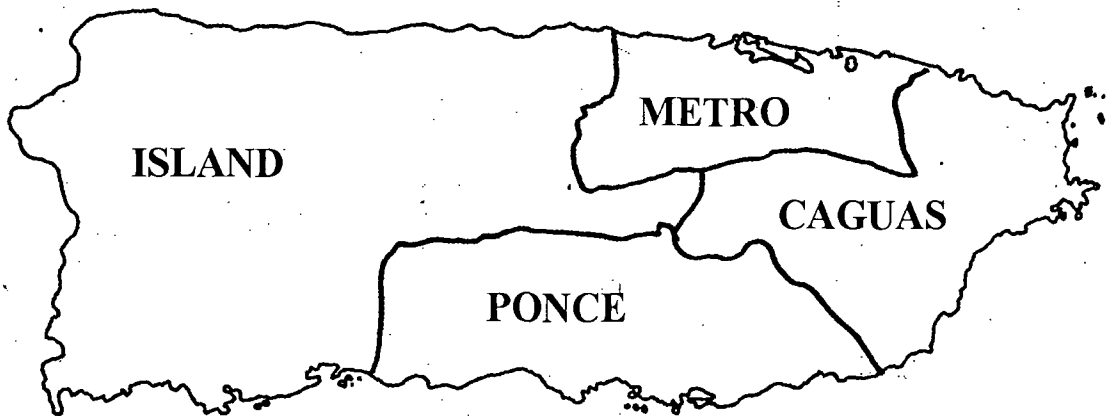
The distribution amongst reported areas of specialisation and geographic region in the sample is also similar to the distribution of these variables in the total population of physicians.

Table 5.2 compares the distribution of the sample surveyed with the distribution reported by Aponte et al. (1974) in their benchmark study (section 4.5). Figure 5.1 shows where the various regions are located in Puerto Rico.

Table 5.2: Sample Distribution (Geographic Region) vis-a-vis 1974 Research

<u>Region</u>	<u>Study 1995</u>	<u>Aponte et al. 1974</u>
Metro	38%	40%
Caguas	7%	15%
Ponce	6%	10%
Island	39%	35%

Figure 5.1: Regions Represented in Survey



Although this convenience sample is not a representative statistical sample of physicians in Puerto Rico, it is believed that the distribution obtained is similar to that in the universe and that of previous studies (Aponte et al. 1974) and thus it can be used for comparison purposes, and to provide the context for the more detailed case investigations undertaken as phase 3 of the research methodology (section 3.4.4).

## **5.2 RESEARCH FINDINGS**

The findings from phase two of the research methodology explained in chapter 3 are presented in this section. The research findings report on the type and size of practice surveyed (section 5.2.1) which was obtained mostly from the first seven questions in the survey instrument (appendixes 1 and 2).

Section 5.2.2 reports on the hypotheses tests (see section 3.4.3.3), the analyses done, and the responses of the physicians to the forty one statements drawn from the literature are compared with the original research or piece of literature from where it was obtained. Section 5.2.3 presents the

findings of the various statistical analyses undertaken (see section 3.4.3.6) to determine if the responses to the statements were independent from the variables under study, namely “gender”, “years in the profession”, and “level of agreement with marketing” (section 3.4.3.5). The statistical analyses for the “gender” variable are presented in section 5.2.3.1, for the “years in the profession” variable in section 5.2.3.2, and for the variable “level of agreement with marketing” in section 5.2.3.3. The impact of the internal and external environment is included in section 5.2.4 and the relationship of the survey to the model appears in section. The model utilised as the general framework for the research (figure 2.3) is analysed in section 5.3.

### 5.2.1 Type and Size of Practice

The physicians surveyed reported that the number of employees in their work places (excluding themselves) ranged from zero to 2000, with the highest number of respondents (Table 5.3) having five or fewer employees (50.5% of those sampled). The modal class was either 2 or 4 employees (11.3% of all who answered had either two or four employees).

Table 5.3: Employees in Medical Work Places

<u>Number of Employees*</u>	<u>Percent</u>	<u>Cumulative Percent</u>
0-5	50.5%	50.5%
6-10	14.4%	64.9%
11-20	7.2%	72.1%
21-50	7.2%	79.3%
51-250	6.2%	85.5%
251+	14.4%	99.9% * *

\*Excludes respondent

\*\*Note: Cumulative percent is not 100% because of the rounding of figures.



Of those employees shown in Table 5.3 above, the number of physicians (excluding the respondent) ranged from zero (24.2%) to 800 physicians. As shown in Table 5.4, the majority of work places employ two or fewer physicians, however.

Table 5.4: Distribution of Physicians Employed in Medical Work Places

<u>Physicians employed (excluding respondent)</u>	<u>Percent</u>	<u>Cumulative Percent</u>
0	24.2%	24.2%
1	23.2%	47.4%
2	8.4%	55.8%
3	7.4%	63.2%
4	6.3%	69.5%
5-10	10.5%	80.0%
11-50	9.5%	89.5%
51-200	6.3%	95.8%
201+	4.2%	100%

In almost one quarter (24.2%) of the cases the person interviewed was the only physician in the work place and in almost half of the work places (47.4%) there were no more than two physicians (the respondent and one other). In essence, physicians in the Puerto Rico work in a profession where the majority spend most of their time at work places with fewer than ten employees (table 5.3), and one or two physicians (table 5.4).

Further review of the data show that the majority of physicians surveyed (73.3%) reported to spend most of their time working in solo or private group practices. Just over half (57.1%) of all the physicians claimed to spend most of their time in private practice as solo practitioners, the majority of them employing no more that three employees (59.3%), with just over one quarter (28%) reporting

one physician employed besides themselves. Thus, small solo practices is the work place for most of the physicians sampled.

### **5.2.2 Statistical Analysis- Hypotheses Test**

Various statistical analyses were performed on the survey results (section 3.4.3.6). This section presents the findings of the various hypothesis tests (section 3.4.3.3). As explained in section 3.4.3.2 a five-point Likert scale allowed the respondents to indicate their attitudes towards the various statements drawn from the literature (chapter 2) by checking how strongly they agreed or disagreed with each of the statements. The resulting means of the respondents' answers were tested for significance against the scale median of 3 (neutral). The t-test was used to determine at a 5% significance level whether each of the hypothesis could be accepted or rejected.

Originally the plan was to perform mean difference tests to compare between the research from the literature and this research. This required that the mean and the variance of the research from the literature be obtained. Only the research from Busson and Darling (1978) provided the means, but lacked the data regarding the variance. The other research in the literature did not provide data on either the mean or the variance. Thus, it was not possible to perform mean difference tests enabling a comparison with the findings from the literature.

To facilitate the analysis and presentation of the survey results the information is divided among the following categories: opinions towards marketing in general (section 5.2.2.1), understanding of what marketing is (section 5.2.2.2), the role of marketing in the medical profession (section 5.2.2.3), the use of marketing by physicians (section 5.2.2.4), public vs. private services (section 5.2.2.5), and health reform (section 5.2.2.6).

### 5.2.2.1 Opinions Toward Marketing in General

According to Kotler (1991 and 1994) there are three reasons why service firms do not use marketing. First many firms view themselves as too small to use formal marketing, second other firms think that the use of marketing is not for professionals, and finally some firms think that the use of marketing is unnecessary. These were posed as statements in the survey instrument (items 8, 9 and 10). Table 5.5 shows the respective hypotheses, as well as the results of the statistical analysis, indicating that all three hypotheses were rejected.

Table 5.5 Hypotheses test of items regarding marketing in general

ITEM	HYPOTHESIS	N	MEAN	STD. DEV	T STAT	DF	P- VALUE	ACCEPT/ REJECT
8. Marketing is not for professionals.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	105	2.30	1.22	-5.899	104	0.0001	REJECT
9. Marketing is necessary for service firms.	$H_0: \mu \leq 3$ $H_1: \mu > 3$	102	3.99	0.94	10.654	101	0.0001	REJECT
10. Formal marketing is not needed for small firms.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	100	2.12	0.94	-9.411	99	0.0001	REJECT

The fact these three hypotheses were rejected suggests an apparent change of attitude towards marketing in general by the professional service provider. The review of the results obtained from the analysis of the other hypotheses in the sections that follow provide additional information as to what might be the reason for this apparent change towards marketing.

### 5.2.2.2 Understanding of what Marketing is

As table 5.6 shows, the hypothesis that marketing is believed to be mostly advertising and promotion (item 11) was accepted, thus this research supports Korgaonkar's (1985) findings. In his research of physician's attitudes, Korgaonkar (1985) found that "...90% of the respondents equate marketing

with advertising and 83% equate it with sales promotion" (p. 12). Likewise, this research also supports Korgaonkar's (1985) findings that physicians are neutral with regards to the statement "it is difficult to agree with modern marketing practices" (item 12).

Table 5.6 Hypotheses test of items regarding understanding about marketing

ITEM	HYPOTHESIS	N	MEAN	STD. DEV	T STAT	DF	P-VALUE	ACCEPT/REJECT
11. Marketing is mostly advertising and promotion.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	101	3.23	1.20	1.909	100	0.9704	ACCEPT
12. It is difficult to agree with modern marketing practices.	$H_0: \mu = 3$ $H_1: \mu \neq 3$	103	2.87	1.11	-1.155	102	0.2506	ACCEPT
13. A good marketer is mostly oriented towards understanding his/her customers needs.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	103	3.91	1.12	8.261	102	1.0000	ACCEPT
15. Medical providers have a clear vision about the concept of service.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	105	2.87	1.16	-1.177	104	0.1209	ACCEPT
16. Generally speaking, medical professionals who use marketing techniques probably provide inferior patient care.	$H_0: \mu = 3$ $H_1: \mu \neq 3$	105	2.58	1.13	-3.789	104	0.0003	REJECT
17. Marketing by medical professionals will help them to be more responsive to the client's needs and wants.	$H_0: \mu \leq 3$ $H_1: \mu > 3$	104	3.24	1.14	2.141	103	0.0173	REJECT
18. Marketing by medical professionals will lower the status of the profession.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	105	2.49	1.12	-4.709	104	0.0001	REJECT
43. A good physician is mostly oriented towards understanding his/her patient's needs.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	95	4.35	0.80	16.501	94	1.0000	ACCEPT

The hypothesis that physicians are neutral about the statement "...medical professionals who use marketing techniques probably provide inferior patient care" (item 16) was rejected. The hypothesis that physicians are mostly in agreement with the statement "marketing by medical professionals will lower the status of the profession" (item 18) was also rejected, contrary to what was expected, given that the majority of physicians interviewed by Korgaonkar (1985) had agreed with the same statement.

The fact that the physicians in this research agreed and also differed from those in Korgaonkar's study with respect to those statements is perhaps explained by the fact the hypotheses for items 13, 43 and 15 (table 5.6) were accepted while the hypothesis for item 17 was rejected- a possible signal of a developing understanding of the overall marketing concept. To probe the marketing concept in general terms the following statement was included early in the survey instrument (item 13): "a good marketer is mostly oriented towards understanding his/her customer needs". Towards the end of the survey instrument a similar statement (item 43) was included, namely "a good physician is mostly oriented towards understanding his/her patient's needs". This was intended to probe the physicians' understanding of the marketing concept. The responses of physicians' surveyed supported acceptance of both hypotheses, thus being in agreement with the basics of the marketing concept (Kotler 1994, 2000) in general terms (item 13) as well as for their profession (item 43). Likewise, the physicians surveyed accepted the hypothesis obtained from Crane (1993) regarding medical providers having a clear vision about the concept of service (item 15). The hypothesis for item 17 was rejected signifying physicians mostly agree with the notion that marketing by medical professionals will help them to be more responsive to the client's needs and wants, the opposite of what Korgaonkar had obtained in his 1985 research. Thus, the findings lend support to a possible general agreement of physicians to the notion of being oriented to understanding patient (customer) needs. This indicates that physicians agree with the "marketing concept" per se, both in general terms and as it relates to their practice of understanding their patient's need, but continue equating

marketing with advertising and promotions. This could signify a paradox. Physicians are mostly in agreement with the marketing concept in general (being customer oriented), and how it relates to their own practice (being patient oriented) but do not fully agree with marketing their profession, as they equate marketing with advertising, which was formerly "outlawed" and is perceived as "touting for trade." This serves as a frame of reference for the interpretation of the results obtained from the other statements, particularly those that have to do with the role of marketing in the medical profession.

The importance of these findings is the shift that appears to have taken place in a decade amongst physicians vis-a-vis the literature reviewed in chapter 2, whereby they recognize the benefits of marketing while downplaying the opinion that it could lower the status of the profession or imply inferior patient care. This shift in the attitude of physicians could signify that now they are more receptive to the use of marketing in their practice and to the benefits such action can bring. However, it could merely reflect the nature of the sample- those participating in the assembly where they were surveyed, being the more enlightened practitioners, or it could be a local effect (ie. confined to Puerto Rico).

#### **5.2.2.3 The Role of Marketing in the Medical Profession**

Hite and Bellizzi (1986) evaluated consumers' attitudes towards accountants, lawyers, and physicians with respect to advertising professional services. The statement they posed to consumers was "it is proper for (accountants, lawyers, and physicians) to advertise." The authors reported (p. 47) that "the results indicate that consumers had a favourable attitude towards professionals with regards to advertising". In this research the statement used was "it is proper for physicians to market their practice" (item 14). Given the negative attitude of physicians (as per the literature, chapter 2) the hypothesis was established as  $H_0: \mu \leq 3$  and  $H_1: \mu > 3$ . As table 5.7 shows the hypothesis was

rejected, further indicating to the apparent shift in physicians' attitudes towards marketing referred to in sections 5.2.2.1 and 5.2.2.2.

Table 5.7 Hypotheses test of items regarding the role of marketing in the medical profession

ITEM	HYPOTHESIS	N	MEAN	STD DEV	T STAT	DF	P- VALUE	ACCEPT/ REJECT
14. It is proper for physicians to market their practice.	$H_0: \mu \leq 3$ $H_1: \mu > 3$	105	3.34	1.23	2.853	104	0.0026	REJECT
19. For better or worse, marketing will play an important role in future development in the medical profession.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	104	3.79	0.92	8.732	103	1.0000	ACCEPT
20. In the future, medical professionals will benefit by understanding more about marketing.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	104	3.88	0.91	9.953	103	1.0000	ACCEPT
21. Medical students should be exposed to marketing in order to better prepare them to establish their practice or career.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	104	3.88	1.03	8.659	103	1.0000	ACCEPT
25. The marketing of fees would adversely affect the public image of physicians.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	101	3.33	1.18	2.793	100	0.9969	ACCEPT

The statement "the marketing of fees would adversely affect the public image of physicians" (item 25) was obtained from the research by Busson and Darling (1978) who asked whether "the advertising of fees would adversely affect the public image of (accountants, attorneys, dentists, physicians)" (page 114, question 10). Busson and Darling obtained a mean answer of 3.83 from physicians (where three is uncertain and four is agree). The responses of physicians' surveyed

supported acceptance of the hypothesis. Thus, this research is agreement with Busson and Barling (1878) suggesting that physician's continue to be hesitant towards the marketing of fees as they fear it may affect the public's image.

As for the future, various statements were posed to the physicians using statements utilized by Korgaonkar in his 1985 research. The statements used were "for better or for worse marketing will play an important role in future development in the medical profession" (item 19); "in the future, medical professionals will benefit by understanding more about marketing" (item 20), and "medical students should be exposed to marketing in order to better prepare them to establish their practice or career" (item 21). The three hypotheses were accepted, thus the findings of this research are in agreement with Korgaonkar (1985).

As previously reported in this chapter, there appears to be a shift in terms of physicians' understanding of what marketing is (section 5.2.2.2) and the results examined in this section also point towards a shift as to the role of marketing in the medical profession. Interestingly, that type of shift was predicted by the physicians in earlier research (Korgaonkar, 1985). The results suggest that physicians in this research predict, just as physicians predicted a decade before, that "...marketing will play an important role in future development in the medical profession", that "...medical professionals will benefit by understanding more about marketing" and that "medical students should be exposed to marketing in order to better prepare them to establish their practice or career". This indicates that the shift that appears to have taken place will likely continue as a better understanding of what marketing is and its role in the medical profession develops. Presumably, that type of continued shift could lead to more use of the various marketing techniques available for the small service entity but currently used in a limited manner as the next section (5.2.2.4) examines.



#### 5.2.2.4 Use of Marketing by Physicians

To evaluate the use (or the potential use) of marketing for their practices and how this compares with previous research, a series of statements drawn from the literature were included in the questionnaire. The statement “marketing my professional service as a physician would be beneficial to me personally” (item 26) was adopted from Busson and Darling 1978 (question 19, page 114) who asked: “advertising my services would be beneficial to me personally”. In that study it obtained a mean answer of 2.21 (where two is disagree) from the physicians interviewed. The mean in this study was 3.32 (where three is uncertain and four is agree). The responses of physician’s surveyed supported rejection of the hypothesis.

Table 5.8 Hypotheses test of items regarding the use of marketing by physicians

ITEM	HYPOTHESIS	N	MEAN	STD DEV	T STAT	DF	P- VALUE	ACCEPT/ REJECT
22. Physicians should perform marketing functions, formally or informally, for their practice.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	105	3.48	1.08	4.502	104	1.0000	ACCEPT
23. The medical staff members should perform marketing functions, formally or informally, for their practice	$H_0: \mu \geq 3$ $H_1: \mu < 3$	105	3.59	1.07	5.647	104	1.0000	ACCEPT
24. Marketing usually increases the price of the product or service offered.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	102	3.25	1.10	2.244	101	0.9865	ACCEPT
26. Marketing my professional services as a physician would be beneficial to me personally.	$H_0: \mu \leq 3$ $H_1: \mu > 3$	103	3.32	1.12	2.898	102	0.0023	REJECT
27. Restrictions on marketing limit competition by refusing to allow physicians to market their services and engage in competitive pricing.	$H_0: \mu \leq 3$ $H_1: \mu > 3$	101	3.15	1.09	1.370	100	0.0869	ACCEPT AT 5% REJECT AT 10%

28. It is very difficult to market competence and quality of service in my profession.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	99	3.45	1.17	3.860	98	0.9999	ACCEPT
31. The marketing of medical services would tend to intensify client dissatisfaction after services have been rendered.	$H_0: \mu = 3$ $H_1: \mu \neq 3$	100	2.77	1.02	-2.247	99	0.0268	REJECT
32. The marketing of medical services would confuse rather than enlighten potential patients.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	99	2.82	1.18	-1.532	98	0.0644	ACCEPT AT 5% REJECT AT 10%
33. The marketing of medical service would assist potential clients in knowing which physicians are competent to handle particular medical problems.	$H_0: \mu \leq 3$ $H_1: \mu > 3$	101	3.11	1.26	0.866	100	0.1943	ACCEPT
34 Marketing techniques in general, are a valuable instrument to communicate to patients.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	100	3.28	1.16	2.405	99	0.9910	ACCEPT
35. The quality of medical services improves when marketing techniques are permitted.	$H_0: \mu \leq 3$ $H_1: \mu > 3$	101	2.81	1.18	-1.601	100	0.9437	ACCEPT
36. To compete effectively, physicians should manage service quality more efficiently.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	95	4.19	0.85	13.572	94	1.0000	ACCEPT
44. The physician-patient relationship is personal and unique, and should not be established as a result of pressures exerted by marketing techniques.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	94	4.37	0.88	15.125	93	1.0000	ACCEPT

46. Existing information sources(i.e. yellow pages, medical lists, etc.) provide in adequate information to guide potential patient's select a physician.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	95	3.67	1.18	5.565	94	1.0000	ACCEPT
47. When other colleagues refer patients to me it is mostly because of how well I am known to my colleagues on a personal basis.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	95	3.08	1.22	0.674	94	0.7491	ACCEPT
48. When referring patients to other colleagues I take mostly into consideration how well I know my colleagues on a personal basis.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	95	2.81	1.27	-1.449	94	0.0753	ACCEPT AT 5% REJECT AT 10%

The statement “restrictions on marketing limit competition by refusing to allow physicians to market their services and engage in competitive pricing” (item 27) was also adopted from the Busson and Darling research (1978). In that (question 9, page 114) those interviewed were asked: “restrictions on advertising limit competition by refusing to allow (accountants, attorneys, dentists, physicians) to advertise and engage in competitive pricing”. Busson and Darling obtained from the physicians interviewed a mean answer of 2.05 which the authors explained as “the respondents did not feel that the restrictions on advertising decreased competition in their professions...” (page 116). The results of this research vary from the Busson and Darling study- the mean in this study is higher at 3.15 and the hypothesis is accepted at the 5% level of significance and rejected at 10% level of significance.

This implies a shift from physicians that believed in 1978 that restrictions did not decrease competition to other physicians while today physicians are mostly “neutral” on the subject. The tendency again is for a shift of attitude, that, if maintained in the future, could signify more

physicians growing to be more at ease with the competitive environment that has developed in the area under study, as described in chapter 4.

On a related issue of marketing and price, the statement "marketing usually increases the price of the product or service offered" (item 24) was included in the survey. This statement was obtained from various research reported in the literature, namely Busson and Darling 1978 (question 8, p.114) which asked "advertising of (accountants, attorneys, dentist, physicians) usually increases the price of the product of service being advertised"; Shimp and Dyer (1978, page 78) who asked attorneys whether the "price of legal services would decrease if legal service advertising were permitted"; and Korgaonkar (1985, page 12) who asked physicians whether "advertising and promotion costs raise the price the consumer has to pay for a product or service". The hypothesis in this research was accepted, thus supporting the findings from the Korgaonkar (1985) study which found that 80% of physicians agreed/strongly agreed. Busson and Darling (1978) obtained a mean answer from physicians of 3.76 (where three is uncertain and four is agree), indicating that "physicians more strongly than the three other professional groups believe that advertising merely serves to increase the prices of the product and services being advertised" (p. 116). The mean in this study of 3.25 is more in the "uncertain" category. The Shimp and Dyer research (1978) found most lawyers interviewed (58.3%) disagreed with the statement "prices of legal services would decrease..." while 32.1% agreed and 9.6% had no opinion. The findings suggest that physicians on the average are mostly neutral in their believe that marketing usually increases prices, vis-as-vis the previous level of agreement with such type of statement (compared to physicians in previous research) and as their attitudes continue to change, over time, they could favour marketing for their practice.

On the issue of marketing competence, two statements were included in the survey. The statement "it is very difficult to market competence and quality of service in my profession" (item 28) was adopted from the Busson and Darling research of 1978 (question 17, page 114). In this research, physicians'

responses supported acceptance of the hypothesis. The mean answer was 3.45 or mostly neutral which is less than the answer of 4.0 (ie. agree) obtained in the Busson and Darling 1978 research. This suggests a possible shift from agreeing (mean of 4.0) to mostly neutral (mean of 3.45) with the issue of the difficulty of marketing of competence and quality of service for their profession. The implication being that physicians' overall negative attitude towards the marketing of competence and quality of service is giving way to the possibility that this can be attained in their profession, for their practice.

The other statement on marketing competence was "the marketing of medical services would assist potential clients in knowing which physicians are competent to handle a particular medical problem" (item 33). This statement was obtained from the Shimp and Dyer research (1978) which asked lawyers whether "legal service advertising would assist potential clients in knowing which lawyers are competent to handle particular legal problems" (p. 79). In that research 58.8% of the respondents disagreed with the statement. Physicians' responses in this study supported acceptance of the hypothesis. The findings support the research by Shimp and Dyer (1978) and suggest physicians do not understand marketing has role in assisting potential patients in selecting a physician, perhaps because of the nature of medical services (see Zeithaml 1981, section 2.4 and figure 2.1).

On issues related to the customer, various statements were presented to the physicians surveyed. The statement "the marketing of medical services would tend to intensify client dissatisfaction after services have been rendered" (item 31) was obtained from the Shimp and Dyer research of 1978 that asked whether "the advertising of legal services would tend to intensify client dissatisfaction after services have been rendered" (p. 79). The largest percentage of attorneys answered no opinion (28.5%). In this research physicians' responses supported rejection of the hypothesis. Another statement related to the customer was "the marketing of medical services would confuse rather than

enlighten potential patients" (item 32). This statement was also obtained from the Shimp and Dyer research (1978) which asked lawyers whether the "advertising of legal services would confuse rather than enlighten potential clients". The majority of them (55.9%) agreed with the statement. In this study, physicians' responses supported acceptance of the hypothesis at the 5% level of significance while at the 10% level of significance the hypothesis is rejected. This suggests there might be a change of attitudes among professional service providers towards the benefits to clients of marketing their practice. The change of attitude regarding this item, however, appears not to be compelling.

The other statement related to the customer was "marketing techniques in general are a valuable instrument to communicate to patients" (item 34). This statement was obtained from the Busson and Darling research (1978) (question 1, page 114) that questioned whether "advertising in general is a valuable way to communicate to consumers". Physician's responses supported acceptance of the hypothesis. This is accordance with the Busson and Darling research (1978). Again, this adds to the apparent shift of service providers towards a more positive attitude towards marketing.

A final statement on the aspect of communicating with the customer included in the survey instrument was "existing information sources (ie. yellow pages, list of physicians, etc.) provide inadequate information to guide a potential patient to select a physician" (item 46). This was obtained from the Shimp and Dyer research (1978) which asked lawyers whether "existing information sources (ie. yellow pages, association referral services, law list, etc.) provide inadequate information to guide potential client's attorney selection" (page 78). In the Shimp and Dyer study 62.7% of lawyers agreed with the statement. In this research physicians' responses supported acceptance of the hypothesis, suggesting professional service providers believe such listings have a role to provide basic information about the practice but do not view such information sources as adequate for the purpose of consumers making a decision as to which professional to select. This is similar with the findings for item 33 ("the marketing of medical services would assist potential clients

in knowing which physicians are competent to handle a particular medical problem”) discussed earlier in this section.

The "part-time marketer" concept advanced by Gummesson (1987, 1990) which was discussed in section 2.4 was tested in the survey with two statements (items 22 and 23). The respective statements were: "physicians should perform marketing functions, formally or informally, for the practice" (item 22) and "the medical staff should perform marketing functions, formally or informally, for their practice" (item 23). Physicians' responses supported the acceptance of both hypotheses. All of this is consistent with their answer to the open ended question about who is responsible for carrying out the marketing practices they engage in and consider most important. The person the physicians claim to be responsible for the most important marketing practice carried out are themselves (41.6% of those that answered) followed by the secretary (20.8% of those that answered). Again, these findings indicate that the physicians that perform marketing understand, possibly intuitively, the essence of the part-time marketer concept as everyone in the organisation, to a greater or lesser degree, impacts on marketing.

Shimp & Dyer (1978) asked lawyers whether "the attorney-client relationship is personal and unique, and should not be established as a result of pressures exerted by advertising" (p.78) and obtained a 64% agreement. In this research the adapted statement was "the physician-patient relationship is personal and unique, and should not be established as a result of pressures exerted by marketing techniques" (item 44). The hypothesis in this survey was accepted. The mean of 4.37 for this statement (where 4 is agree and 5 is strongly agree) is the highest mean obtained from any of the statements in the survey, thus the physicians' responses, on average, place a high level of agreement in regards to the physician-patient relationship. The implication, thus, is that physicians value the physician-patient relationship and are concerned that it can be adversely affected by marketing actions. Such a view is somewhat "universal" amongst physicians, regardless of their "gender"

(section 5.2.3.1), "years in the profession" (section 5.2.3.2) or "level of agreement with marketing" (section 5.2.3.3). The importance of the physician-patient relationship is further analysed in chapter 6 as a result of the findings from the case studies.

The literature (section 2.8.5) referred to the entrepreneurs' "personal contact network" stating that the key characteristic is that the focal person (the entrepreneur) knows the individuals well in his/her personal contact network (Aldrich et al. 1989; Mintzberg 1973; Johannisson 1984, 1986, 1987a, 1987b, 1988a, 1988b; Johannisson and Peterson 1984; Aldrich and Zimmer 1986, Dubini and Aldrich, 1991). To probe this aspect of networking within the medical practice and the physician's own personal contact network as it relates to the referral of patients, the following statements were included in the survey instrument: "when other colleagues refer patients to me, it is mostly because of how well I am known to my colleagues on a personal basis" (item 47) and "when referring patients to other colleagues I take mostly into consideration how well I know my colleagues on a personal basis" (item 48). Physicians' responses supported acceptance of the hypothesis to item 47 ("when other colleagues refer patients to me...") while for item 48 ("when referring patients to other colleagues...") the hypothesis was accepted at the 5% level of significance and rejected at the 10% level of significance. A possible marketing implication of this result is that physicians could foster personal relationships with colleagues though presumably they would not let such actions by them impact on their own criteria when referring patients. The case studies researched (chapter 6) further explore this issue and reports on the physician's patient referral system (section 6.3).

Item 36 "to compete effectively, physicians should manage service quality more efficiently" was obtained from Crane (1993, p. 8) who proposed that the "...need to manage service quality, both technical and functional... may be the only way to create differentiation..." from other suppliers of similar services. The responses of physicians' support the acceptance of this hypothesis and support the notions of managing service quality advanced by Crane (1993). Further related to the issue of



quality in medical services, the physicians surveyed were asked to indicate their level of agreement with the statement "the quality of medical services improves when marketing techniques are permitted" (item 35). The physicians' responses supported the acceptance of the hypothesis and give support to the literature (section 2.5) in terms of the disagreement professional service providers have regarding marketing techniques improving the quality of medical services.

These answers suggest that the use of marketing techniques by physicians is limited and that they prefer to place their efforts on managing service quality and maintaining focus on the personal and unique nature of the physician-patient relationship. This can not be construed as a lack of interest, lack of understanding of marketing nor of them not being market oriented. What it probably suggests is that physicians want to concentrate their efforts on the basis of quality service and the patient-physician relationship, in essence in the marketing concept of identifying and satisfying customer needs vis-a-vis the "trappings" of marketing (Ames, 1970).

All of this is in strong agreement with the relationship marketing concept (Berry, 1983; Berry and Parasuraman, 1991; Jackson, 1985; Grönroos, 1989, 1990a, 1990b; Gummesson 1987, 1990 and 1996; Levitt, 1986), discussed in sections 2.2 and 2.4.4. According to the findings of this study, physicians place a special emphasis on the relationship with patients in a manner consistent with the concept of relationship marketing, whereby the focus is on long-term relationship-building (vis-a-vis a short-term transaction oriented goal) resulting in the creation of "strong customer loyalty" (Kotler 1994, p. 48). Given these findings, the research based on case studies (phase three of the research methodology) aims to better understand the physician-patient relationship and its implications for marketing. The case study analysis (chapter 6) concludes that the value physicians place on the physician-patient relationship accounts for the particular marketing actions they perform or fail to perform (section 6.3).

### 5.2.2.5 Public vs. Private Services

To evaluate the aspect of how physicians perceive public versus private health services and how this compares with previous research, various statements from the research by Aponte et al. (1974) were included in the survey. Table 5.9 presents the statements (items 29, 30 37, and 45), their respective hypotheses, as well as the statistical analysis, indicating three of the four hypotheses were accepted.

Table 5.9 Hypotheses test of items regarding public vs. private services

ITEM	HYPOTHESIS	N	MEAN	STD DEV	T STAT	DF	P- VALUE	ACCEPT/ REJECT
29. The majority of physicians that continue to be employed by the public health system are not very competent.	$H_0: \mu \leq 3$ $H_1: \mu > 3$	101	2.08	1.21	-7.675	100	1.0000	ACCEPT
30. Working "part-time" with the government health system adds prestige to the physician.	$H_0: \mu = 3$ $H_1: \mu \neq 3$	100	2.75	1.10	-2.264	99	0.0258	REJECT
37. Those that obtain medical services provided by the government receive the same quality of service as that provided by private medical service providers.	$H_0: \mu \leq 3$ $H_1: \mu > 3$	95	2.36	0.99	-6.332	94	1.0000	ACCEPT
45. There are significant differences between the physician-patient relationship in the private sector as compared to that in the public sector.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	95	3.72	1.20	5.815	94	1.0000	ACCEPT

Physicians' responses supported the acceptance of the hypothesis for the statement "those that obtain medical services provided by the government receive the same quality of service as that provided by private medical services providers" (item 37). The results of this research are in line with the Aponte et al. (1974) study which found that "the great majority of physicians... disagree with this statement" (p. 668).

It would appear that this opinion is influenced by what physicians understand about the competence of physicians in the public sector since physicians' responses supported the acceptance of the hypothesis for the statement "the majority of physicians that continue to be employed by the public health system are not very competent" (item 29). This concurs with the findings of Aponte et al. (1974) who found that "the great majority of physicians... disagree with this statement" (p. 668). The similarity of the response of this statement, as well as the majority of other statements related to the Aponte et al. (1974) study, appears to indicate a very consistent belief, throughout the years, of the majority of the physicians in Puerto Rico regarding the level of quality provided in government facilities as well as the competence of those that are employed by the public health system.

The responses of physicians to the statement "working part-time with the government health system adds prestige to the physician" (item 30) supported the rejection of the hypothesis. The mean response of 2.75 (where 2 is disagree and 3 is neutral), appear to be similar to the results of the Aponte et al. 1974 research which states that "the opinion of physicians agreeing or disagreeing with that statement is more or less divided equally" (p. 669). Perhaps the reason for this difference in the quality of services is because the physician/patient relationship which physicians claimed as of most importance (statement 44, as explained earlier in section 5.2.2.4) is best obtained in the private setting. This appears to be the case when the statement "there are significant differences between the physician-patient relationship in the private sector as compared to that in the public sector" (item 45) is examined. Here physicians' responses supported acceptance of the hypothesis and appear to

support the results obtained by Aponte et al. (1974) where “around 60% of physicians... understand that there is... much difference” (p. 669). For all of these four statements there is a remarkable similarity with the Aponte et al. study. Section (5.2.3.6) also includes statements from the Aponte et al. 1974 research, where further analysis in this area is explained.

### 5.2.2.6 Health Reform

The health reform in the area under study (chapter 4), warranted examination of physicians’ opinions on this matter. Table 5.10 presents the statements related to the health reform, their respective hypotheses, and the statistical analysis indicating most of the hypotheses (3 out of 5) were rejected.

Table 5.10 Hypotheses test of items regarding health reform

ITEM	HYPOTHESIS	N	MEAN	STD DEV	T STAT	DF	P- VALUE	ACCEPT/ REJECT
38. The introduction of the health service card helps low income patients obtain better quality in health services	$H_0: \mu \geq 3$ $H_1: \mu < 3$	95	2.46	1.30	-4.015	94	0.0001	REJECT
39. The health reform helps low income patients obtain better quality in health services.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	94	2.37	1.20	-5.070	93	0.0001	REJECT
40. Government should establish norms and regulations for the physicians to assure quality of health services to the people.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	94	4.00	1.25	7.738	93	1.0000	REJECT
41. The health reform has had a positive impact in my practice.	$H_0: \mu \leq 3$ $H_1: \mu > 3$	93	2.42	1.08	-5.201	92	1.0000	ACCEPT
42. When the health reform is completed physicians will have to do more than what is currently needed.	$H_0: \mu \geq 3$ $H_1: \mu < 3$	95	3.27	1.21	2.211	94	0.9853	ACCEPT

The quality of health services for low income patients under the "health reform" in general (item 39) and under "the government's introduction of the health service card..." (item 38) were included for the physician's to express their level of agreement/disagreement. Responses to both statements supported the rejection of both hypotheses suggesting physicians are not in agreement with the government's position regarding the benefit to low income patients that the changes the health system is designed to achieve. In terms of the impact of health reform in the practice, the statement "the health reform has had a positive impact on my practice" (item 41) was included. Physicians' responses support the acceptance of the hypothesis, thus lending support to the negative impact physicians understand the health reform will have on their practices (Friedman 1993). In order to consider what the future holds for physicians under the health reform, the statement "when the health reform is completed, physicians will have to do more than what is currently required" (item 42) was included in the survey. Physicians' responses support the acceptance of the hypothesis, thus lending support to the concerns of physicians in the area under study (Friedman, 1993) and further questioning the benefits that the government's health programme would bring for both patients and physician's practices.

To evaluate how physicians felt about the role of the government in regulating them and how these opinions compare to previous research, the following statement for the Aponte et al. research of 1974 was included: "government should establish norms and regulations for the physicians to assure quality of health services to the people" (item 40). This research found physicians' responses supported the rejection of the hypothesis. The mean of 4 (signifying "agree") obtained in the research supports the findings of Aponte et al. (1974) where "the great majority [61.2%] agree with this premise" (p. 670).

The five statements from the Aponte et al. (1974) research included in this study (four analysed in section 5.2.2.5 above and one in this section) showed very similar results from the physicians

answering the present survey. The 21 year gap between the two pieces of research, combined with the fact that 62.9% of the physicians surveyed in 1995 stated they had been in practice 20 years or less, means that the opinions of the physicians surveyed in 1995, for the most part, come from physicians other than those surveyed 21 years earlier. This leads to the conclusion that the great similarity in answers cannot be attributed to a possible lack of a change in attitudes of physicians with respect to the issues under investigation, but rather to a set of attitudes that, after 21 years, are still appropriate regarding public vs. private services and health reform. The opposite is true regarding marketing and its use for the practice of professional services where, as compared to other studies, it appears that a significant change has occurred, favouring the use of marketing.

To summarize the findings of section 5.2.2, it is appropriate to point out that the mean of the responses for the majority (38) of the 41 statements (items 8 to 41) are in the middle range (slightly below or slightly above the neutral category of 3). None of the statements obtained a mean of less than two (where 2 is "disagree" and 1 is "strongly disagree"). Only three statements obtained a mean response above 4 (where 4 is "agree" and 5 is "strongly agree"). The three statements are:

- item 44: "The physician-patient relationship is personal and unique, and should not be established as a result of pressures exerted by marketing techniques" - mean 4.37
- item 43: "A good physician is mostly oriented towards understanding his/her patient needs"- mean 4.35
- item 36: "To compete effectively, physicians should manage service quality more efficiently"- mean 4.19

These three statements which physicians, on average, agreed with, serve to highlight an important finding of the survey: physicians value the physician-patient relationship and understand it should not be established based on pressures exerted by marketing techniques, they are patient centred and

understand the importance of efficiently managing service quality as a means to compete effectively. Furthermore, as will be discussed in the next sections, all three items were found not to have significant differences amongst male vis-a-vis female physicians (section 5.2.3.1). The two items which, on average, physicians agreed with the most (items 44 and 43) were independent of the variable “years in the profession” (section 5.2.3.2) and “level of agreement with marketing” (section 5.2.3.3) suggesting physicians are in agreement with such items regardless of how long they have been in the profession or whether they strongly agree/disagree or are neutral about marketing. As previously explained in section 5.2.2.4, the survey of cases (phase three of the research methodology) further examines these issues and presents the results in chapter 6.

### **5.2.3 Statistical Analyses- Variables Under Study**

The data obtained from the survey was also analysed in terms of the various variables under study, namely “gender”, “years in the profession”, and “agreement with marketing” (section 3.4.3.5). The sections that follow examine the analysis undertaken for each of the variables under study and the findings.

#### **5.2.3.1 Gender**

In the case of the “gender” variable, the purpose was to observe if significant differences (at the 5% significance level) exist between “gender” and the various statements under study. Thus, the null hypothesis regarding the gender variable is  $H_0: \mu_1 = \mu_2$  versus  $H_1: \mu_1 \neq \mu_2$  where  $\mu_1$  is the mean response of male physicians to each statement and  $\mu_2$  is the mean response of female physician to the same statement. The t-test is appropriate for conducting such analysis in a situation where the variance is unknown and the sample size is over 30 (Weiers, 1998). The SAS statistical package was utilised for this.

Appendix 9 shows the two sample t test for the means of each of the 41 statements within the gender variable. Only in four (of the 41 statements) was there a significant difference between the opinion of male versus female physicians. These statements were:

- item 17: “marketing by medical professionals will help them to be more responsive to the client’s needs and wants”
- item 19: “for better or for worse, marketing will play an important role in future development in the medical profession”
- item 33: “the marketing of medical service would assist potential clients in knowing which physicians are competent to handle particular medical problems”
- item 34: “marketing techniques in general, are a valuable instrument to communicate to patients”

The four statements are very related to marketing and the medical practice, and female physicians are more in agreement with all four statements than male physicians. Physician’s attitudes about marketing for the most part, however, were not found to be related to the gender of the service provider.

#### **5.2.3.2 Years in the Profession**

The purpose here was to observe if significant differences exist between the experience of the practitioner (“years in the profession”) and the various statements. Given that six categories of responses were included in the questionnaire (appendixes 1 and 2) for the variable “years in the profession”, the null hypothesis is  $H_0: \mu_1=\mu_2=\mu_3=\mu_4=\mu_5=\mu_6$  versus  $H_1$ : not all the means are



equal, where  $\mu_1$  is the mean response of all physicians with 0 to 5 years in the profession,  $\mu_2$  is the mean response of all physicians with 6 to 10 years in the profession, etc. This type of analysis for comparing the means of more than two populations (versus male/female which are two populations) requires the use of one way ANOVA (analysis of variance) (Chase and Bown, 1997). The SAS statistical package was used for this.

Appendix 10 shows that at the 5% significance level there are no differences in the means utilizing the one way ANOVA as well as the Kruskal-Wallis Test (a non parametric chi-square approximation test). That is, there is no relationship, at the 5% level of confidence, between “years in the profession” and the opinions of physicians to the various statements included in the questionnaire. At the 10% significance level only four statements show difference in the means, both in the one way ANOVA as well as in the Kruskal-Wallis test), thus indicating a relationship, at the 10% level of significance, between the “years in the profession” and four statements from the questionnaire. The four statements are:

- item 17: “for better or for worse, marketing will play an important role in future development of the profession”
- item 33: “the marketing of medical service would assist potential clients in knowing which physicians are competent to handle particular medical problems”
- item 36: “to compete effectively, physicians should manage service quality more efficiently”
- item 42: “when the health reform is completed physicians will have to do more than what is currently required”

Given that there is a relationship at the 10% level of significance between the response to these four statements and the variable “years in the profession”, an attempt was made to determine what this relationship might signify.

Appendix 11 shows the results of the Duncan’s Multiple Range Test, which compares the means of each of the six age categories against each other for each of these four statements. A pattern is apparent only for statement 42 (“when the health reform is completed physicians will have to do more than for what is currently required”), suggesting that the younger physicians (those that have been in the profession for up to five years, and those with 6 to 10 years in the profession) are more in agreement with the statement. That is, the mean response is shown as more in agreement. For the other three statements, even though there are differences between the means, thus making them related to years in the practice, a pattern was not found.

In general terms, then, this research found that there was no relationship between the years a physician has been practising and the statements under study. Physician’s attitudes about marketing, thus, were not found to be related to the years they have been in the profession. According to the model utilised as the general framework for the research (figure 2.3), as the years the service provider has been in practice increases, the more likely his/her practice has moved into the various stages of marketing development for the small service firm, as a result of changes in his/her attitudes towards marketing. Thus, the findings of this research do not support that aspect of the general framework utilised for this research. A possible reason for this behaviour is that the longer the physician has been practising, the more likely he/she initiated the profession at a time marketing activities were banned for the medical practices and they continue to have a reserved attitude towards marketing years after the restrictions have been lifted.

### 5.2.3.3 Level of Agreement with Marketing

According to the general framework utilised for the research, what physicians believe about statements related to marketing is related to the attitude of the physician in terms of the level of agreement with marketing (section 3.4.3.5). Given the concern for obtaining biased responses to a direct question whereby physicians would have categorized themselves as in agreement, disagreement, or neutral about marketing, the methodology designed provided for a method to create the variable “level of agreement with marketing” based on data from the questionnaire (section 3.4.3.6).

For measuring the level of agreement/disagreement with marketing four particular statements were included in the questionnaire. As explained in chapter 3 (section 3.4.3.6) the four statements were selected as representative of the literature which, combined, provided a measure to assist in classifying a physician’s level of agreement/disagreement with marketing.

In order to create the variable “level of agreement/disagreement with marketing” two analyses were performed, namely correspondence analysis and cluster analysis. Since the variables are categorical, the correspondence analysis is used in this research to reduce the dimensionality (number of variables) in order to obtain the principal factors that explain most of the structure of the variables that will be used for the cluster analysis. “Cluster analysis (allows us) to sort cases into groups, or clusters, so that the degree of association is strong between members of the same cluster and weak between numbers of different clusters” (SAS Institute 1989a, p. 519). The interest is in identifying groups of respondents that have similar attitudes towards marketing amongst themselves and yet there is a difference amongst the groups.

Appendix 12 shows the perceptual map utilising the two most important factorial coordinates that better explain the variability of the data. Utilizing the factorial coordinates obtained from the correspondence analysis, a hierarchical cluster analysis was conducted (see appendix 13). Through the cluster analysis it was possible to determine three categories of level of agreement with marketing, namely “strongly in agreement with marketing”; “strongly in disagreement with marketing”; and “neutral about marketing”, and thus create a new variable that would permit analysis of the responses of physicians in terms of their level of agreement/disagreement with marketing. The resultant distribution was 9.5 % “strongly in disagreement with marketing”; 75.2% “neutral about marketing”; and 15.2% “strongly agreement with marketing.” Thus, three quarter of the respondents did not exhibit a strong position of agreement or disagreement with the statements under study, preferring a neutral, or close to neutral position.

Once three categories had been constructed (“strongly agree”, “strongly disagree”, “neutral”) the goal was to compare the means of the attitude towards the statements from the literature (items 8 to 48 in the questionnaire) of the respondents. Thus, the null hypothesis is  $H_0: \mu_1 = \mu_2 = \mu_3$  versus  $H_1$ : not all means are equal. Appendix 14 shows the analysis of variance (ANOVA) performed with the statistical package SAS which was utilised to compare the means of the three populations (“strongly agree”, “strongly disagree”, “neutral about marketing”).

At the 5% level of confidence there are significant differences (both utilizing ANOVA and the Kruskal-Wallis test) for over half (23) of 41 the statements. At the 10% significance level two additional statements showed significant differences. A review of the data (appendix 14) shows there was no relationship between the “level of agreement with marketing” variable and all the statements regarding the Health Reform Programme (items 38, 39, 40, 41 and 42). Similarly, there was no relationship between the variable “level of agreement with marketing” and the

majority (3 out of 4, or 75%) of the statements regarding public versus private health services (items 29, 30 and 45). This appears to support the findings in sections 5.2.2.5 and 5.2.2.6 where the attitude of physicians towards public vs. private services and health reform have remained practically unchanged, while attitudes towards marketing in general and for the medical practices in particular have experienced a change towards more acceptance.

A review of the statements where a relationship was found with regards to the variable "level of agreement with marketing", shows most of the statements have to do with marketing issues in general, and the marketing of medical practices in particular. Duncan's Multiple Range Test for each of the statements where a relationship was found (with regards to the variable "level of agreement with marketing") was reviewed. Table 5.11 provides a summary that characterizes the respondents by their "level agreement with marketing" utilizing the 25 statements (items from the questionnaire) where a relationship was found at the 5% and 10% level of significance. For individuals that are "neutral with marketing", for example, the tendency is mostly to be neutral with regards to the statements (not committing to either extreme of "strongly agree" or "strongly disagree" with the statements). The respondents that are "neutral to marketing", which account for 75% of all surveyed, differed from those that "strongly disagree with marketing" and "strongly agree with marketing" in that their perceptions are neutral to items 14, 16, 17, 18, 22, 26, 31, 32, 34 and 47 and are in agreement with items 13, 20, 21, 23 and 36. Since the means for items 9, 10, 19, 33, 35 and 37 are statistically equal, the responses to those statements (items) do not characterize the respondents that are "neutral to marketing".

Table 5.11: Statements related to “level of agreement with marketing”

Range where mean response for the statement is located	Strongly disagree with marketing	Neutral to marketing	Strongly agree with marketing
1.0-1.5	17		8, 18
1.5-2.0	14, 26, 37		10, 16, 32
2.0-2.5	10*, 22, 23, 33*, 34, 35*, 47	10*, 37*	13, 31, 37*
2.5-3.0	13, 21, 27	16, 18, 31, 32, 35*	24, 25
3.0-3.5	8, 12, 16, 18, 19*, 20	14, 17, 22, 26, 33*, 34, 47	
3.5-4.0	9*, 24, 31, 32	9*, 13, 19*, 20, 21, 23	27, 35
4.0-4.5	25	36	22, 33
4.5-5.0			9, 13, 14, 17, 19, 20, 21, 23, 26, 34, 36

\*Means are statistically equal, thus attitudes regarding the statement are shared between respondents in various “levels of agreement with marketing” .

The individuals that “strongly disagree with marketing” tend to have an attitude of strong disagreement with item 17; disagreement with items 14, 22, 23, 26, 34, 37, and 47; neutral with items 8, 12, 13, 16, 18, 20, 21, and 27; in agreement with items 24, 25, 31, and 32; and they are not in strong agreement with any of the items.

The individuals that “strongly agree with marketing” have as a characteristic that their attitudes are mostly in one extreme of the spectrum- they strongly agree with items 9, 13, 14, 17, 19, 20, 21, 23, 26, 34, and 36 (while they have an attitude of strong disagreement with items 8 and 18; they disagree with items 10, 12, 16, 31 and 32; and are neutral with items 24 and 25).

Further review of the patterns that emerge from the respondents that are classified as “strongly in disagreement with marketing”, “neutral to marketing” and “strongly in agreement with marketing” vis-a-vis their mean responses to the statements (table 5.11) provide additional support to the finding that the “level of agreement with marketing” of the of service provider

appears to have an impact on the attitude he/she has towards statements related to marketing of their practices. Statement 17 (“marketing by medical professionals will help them to be more responsive to the client’s needs and wants”) had the most definitive pattern of those who tend to be “strongly in agreement with marketing” and are mostly in strong agreement with the statement, those that tend to be “strongly in disagreement with marketing” and are mostly in strong disagreement with the statement, and those that tend to be “neutral to marketing” and are mostly neutral to the statement. A similar pattern occurred in regards to the “level of agreement/disagreement/neutral with marketing” and the level of agreement with other statements in the survey. Three statements had physicians that “strongly agree with marketing” and also strongly agreed with the statement, while those that “strongly disagreed with marketing” disagreed with the statement and those “neutral to marketing” were neutral to the statement. The three statements are:

item 14: “It is proper for physicians to market their practice”.

item 26: “Marketing my professional services as a physician would be beneficial to me personally”.

item 34: “Marketing techniques in general, are a valuable instrument to communicate to patients”.

Two statements had physicians that “strongly agree with marketing” and strongly disagreed or disagreed with the statement, while those that “strongly disagreed with marketing” agreed with the statement and those “neutral to marketing” were neutral to the statement. The two statements are:

item 31: “The marketing of medical services would tend to intensify client dissatisfaction after services have been rendered”.

item 32: “The marketing of medical services would confuse rather than enlighten potential patients”.

These two (items 31 and 32) had the statements expressed negatively, thus the patterns are similar to the one found for items 17, 14, 26, and 34. That is: physicians in “strong agreement with marketing” are in some level of agreement with the positive implication of the statement, while those in “strong disagreement with marketing” are in some level of disagreement with the positive implication of the statement, and those “neutral to marketing” are also neutral to the statement.

The review of the patterns in regards to “level of agreement with marketing” vis-a-vis the level of agreement with the statements show a change towards an attitude more in agreement with marketing for the medical practice. For example, item 13 (“a good marketer is mostly oriented towards understanding his/her customers needs”) and 18 (“marketing by medical professionals will lower the status of the profession”) show that those who “strongly agree with marketing” are also in strong agreement with the statements, while those that “strongly disagree with marketing” are neutral to the statements, and the ones “neutral to marketing” are either neutral (item 18) or in agreement with the statement ( item 13). Similarly, items in the survey that had to do with how respondents view the future (item 20: “in the future, medical professionals will benefit by understanding more about marketing” and item 21: “medical students should be exposed to marketing in order to better prepare them to establish their practice or career”) had those that “strongly agree with marketing” also strongly agree with the statements, while those that “strongly disagree with marketing” are neutral to the statements, and those “neutral to marketing” agree with the statements.

This analysis indicates that most statements in the survey (mainly those related to marketing issues) are related to the variable “level of agreement with marketing” and the review of the results indicate a series of patterns that provides support to the importance the “level of agreement with marketing” has in the service provider’s attitude towards marketing for the



practice. In terms of the general framework utilised for the research, the results indicate that what physicians believe about statements related to marketing is related to the attitude of the physician in terms of the “level of agreement/disagreement/neutral about marketing.” Thus the research suggests that the attitude of the service provider could be key in terms of how the service provider views a variety of issues related to the practice (including marketing). The fact not all statements follow a definitive pattern (ie. respondents that “strongly agree with marketing” that also are in strong agreement with the statements related to marketing, etc.) could signal that the debate about utilising marketing techniques for professional service providers continues amongst physicians, despite the more positive shift towards marketing that appears to have taken place over the last decade (sections 5.2.2.1 and 5.2.2.2).

According to the model utilised as the general framework for the research (figure 2.3) the attitude of the service provider is part of the internal environment of the firm and has an influence in the behaviour of the service provider. The findings support that aspect of the general framework utilised for this research.

Utilising the three categories that were constructed (“strongly agree with marketing”, “strongly disagree with marketing”, and “neutral to marketing”) the mean of the responses from the statements was then analysed to determine whether they differed with respect to the variable “years in the profession” and “type of marketing activity undertaken”. The null hypothesis was established as  $H_0$ : the variable “level of agreement with marketing” and “years in the profession” are independent; versus  $H_1$ : the variable “level of agreement with marketing” and “years in the profession” are related. A chi-square test was utilized to determine statistically if there was a relationship between the variables and the results are included in appendix 15. Given the low number of observations in some cells when the chi-square test was conducted, the data for “years in practice” was collapsed into two categories (“0 to 20 years” and “over 20

years”). Fisher’s Exact Test was also utilised with both the collapsed and the non collapsed data to obtain a reliable test of the relationship amongst the variables, given the small samples.

The results of this research (appendix 15) indicate that the variable “level of agreement with marketing” and “years in the profession” are independent at the 5% level of significance. According to the model utilised as the general framework for the research (figure 2.3) it might be expected that as the years the service provider has been in practice increases, the more likely he/she is more in agreement with marketing (and thus more marketing activities are undertaken). The findings of this research, however, do not support that aspect of the general framework utilised for this research as the “level of agreement with marketing” and the “years in the profession” were found not to be related.

With the purpose of determining if there is a relationship between the three categories of level of agreement with marketing and the type of marketing activity undertaken (item number 49 in the questionnaire) the null hypothesis was established as  $H_0$ : the variable “level of agreement with marketing” and the “type of marketing activity undertaken” are independent; versus  $H_1$ : the variable “level of agreement with marketing” and the “type of marketing activity undertaken” are related. A chi-square test was utilised to determine statistically at the 5% level of significance if there was a relationship between the variables and the results are shown in appendix 16. Given the low number of observations in some cells when the chi-square test was conducted, the data for “type of marketing activity undertaken” was collapsed into two categories (“categories 1 and 2” and “categories 3 and 4”). Fisher’s Exact Test was also utilised with both the collapsed and the non collapsed data to obtain a reliable test of the relationship amongst the variables, given the small samples.

According to the results (appendix 16) the variable “level of agreement with marketing” and “type of marketing activity undertaken” are independent. This again, does not support the model utilised as general framework for the research (figure 2.3) which stipulated that as the service provider is in more agreement with marketing, more marketing activities are undertaken for the firm.

Of the three variables under study (namely “gender”, “years in the profession”, and “level of agreement with marketing”), the variable where most relationship was found was “level of agreement with marketing”.

#### **5.2.4 Impact of the Internal and External Environment**

The impact of both, the internal and the external influences on the evolution of marketing in the small professional service firms, as per the model utilised as the general framework for the research (figure 2.3), was measured against the variable “years in the profession”. According to the model (figure 2.3) it is expected that the longer the service provider has been in the profession, the more likely it is that the external environment will have a higher impact on the firm, conversely, the shorter the time in the profession the greater the impact of the internal environment on the service firm. The 41 statements included in the questionnaire were examined to determine those that were related to either the external or the internal environment and whose responses could be equated to the direction of the model. Item 30: “working “part-time” with the government health system adds prestige to the physician”, for example, was not included as it was not easy to classify as internal nor external environment and it was not evident from the model how physicians should respond to it based on the years in the profession. A total of 27 statements (16 having to do with the internal environment and 11 having to do with the external environment) were utilised for computing the indexes. The items selected for the indexes were transformed, as need be, so that the responses would go in the

same direction as the model utilised as the framework for the research (ie. according to the model, the longer the service provider has been in the profession, the more likely it is that the external environment will have a higher impact on the firm, conversely, the shorter the time in the profession the greater the impact of the external environment on the service firm).

To perform this analysis two indexes were developed: one to measure the impact of external variables in the respondents and another to measure the impact of the internal variables in the respondents. To obtain the indexes the PRINQUAL procedure (the Principal Components of Qualitative Data) and the principal component analysis were utilized. "The PRINQUAL procedures obtains linear and nonlinear transformations of variables using the method of altering least squares to optimize properties of the transformed variables' covariance or correlation matrix" (SAS Institute 1989b, p. 1265). "The principal component analysis is a multivariate technique for examining relationship among several quantitative variables". (SAS Institute, 1989b, p. 1240).

Utilizing PRINQUAL and the principal component analysis, each respondent (who was not missing data in the variables used for each index) was given an index for the external factor and an index for the internal factor. Appendix17 has the PRINQUAL and Principal component analysis computations utilising the statistical package SAS for the index of the internal environment. It shows all 16 variables (16 statements in the questionnaire having to do with the internal environment) run in the same direction based on the model. Appendix18 has the PRINQUAL and principal component analysis computation utilising the statistical package SAS for the index of the external environment. It shows that out of the 11 variables (statements in the questionnaire having to do with the external environment) all but one (TP 59) run in the same direction based on the model. That one variable, which stands for item 46 in the questionnaire- ("existing information sources i.e. yellow pages, medical lists, etc. provide

inadequate information to guide potential patient's to select a physician") was eliminated from the index. Appendix 19 shows the final computations for the external index based on the 10 variables (after one of the variables was dropped from the analysis, as explained above).

The variables utilised for each of the indexes were transformed utilising PRINQUAL and were then weighted utilising the first principal component. The resultant indexes were placed on a scale of 0 to 100 (where 100 represents maximum impact of the internal or external variable) to facilitate the use of the indexes. These computations are included in appendix 20. The indexes were then compared to years in the profession of the physicians in order to perform the various hypothesis tests. The null hypothesis is  $H_0: \mu_1 = \mu_2 = \mu_3 = \mu_4 = \mu_5 = \mu_6$  versus  $H_1$ : not all the means are equal, where  $\mu_1$  is the mean index (either for the external or for internal factors) of physicians with 0 to 5 years in the profession,  $\mu_2$  is the mean index of physicians with 6 to 10 years in the profession, etc. As previously explained, for these types of analysis of comparing the mean of more than two populations, one way ANOVA was utilised. The statistical package SAS was utilised.

Appendix 21 contains the results of the ANOVA for the internal and external indexes in relation to the variable "years in the profession." The means of the indexes for each of the groups of "years the profession" are equal, indicating there are no significant differences between the years in the profession and either the internal or the external indexes. According to the model it was expected that the longer the service provider has been in the profession, the more likely it is that the external environment will have a higher impact on the firm, conversely, the shorter the time in the profession the greater the impact of the internal environment on the service firm. Thus, the model utilised as the general framework for the research (figure 2.3) appears not to be the most adequate to explain the behaviour of the physicians' surveyed.

Therefore an area that needs to be explored in the case study is what impact, over time, does the internal and external environments have on the professional service firm.

### **5.3 RELATIONSHIP OF THE STATISTICAL SURVEY TO THE MODEL AND AREAS TO EXPLORE IN THE CASE STUDY**

As explained in section 5.2.3.2 the findings do not support the original construct of the model in terms of there being a relationship in the firm moving into the various stages of marketing development as the number of years the physician is in practice increases. Thus, an area to investigate in the case study is why physicians, over time, do not move into the various stages of marketing development as the literature indicates. Similarly, as explained in section 5.2.3.3, the findings do not support the model's construct that as the years the service provider has been in practice increases, the more likely he/she is to be more in agreement with marketing. The case studies, therefore, should explore why agreement with marketing is not increasing as the service provider becomes more experienced in running his/her practice. The research findings do not support the model's construct in terms of the changing impact on the firm, over time, of the external and internal environments (5.2.4), prompting as areas to investigate in the case studies what impact does both the external and internal environments have, over time, in the practice and what are the implications for marketing.

The survey does indicate that the variable where most relationship was found was "level of agreement/disagreement/neutral with marketing" (section 5.2.3.3). Thus, according to the findings, how the physicians responds to a variety of statements is related to the level of agreement he/she has with marketing. This impacts on the attitude of the service provider towards the use of marketing for the practice and could have an influence in his/her behaviour. The findings of the survey suggest the aspect of the physicians-patient relationship to be most

important, attaining the highest level of agreement, on average, of by the respondents. The case study provides an opportunity to explore why physicians place an important emphasis on the physician-patient relationship (vis-a-vis other matters), and what are the marketing implications of this behaviour.

As explained in this section, the statistical survey has raised questions as to the adequacy of the model utilised as the general framework for this research. These issues, together with the literature review helped set the context for phase three (qualitative research based on case studies) of the investigation.

#### **5.4 SUMMARY**

Clearly, the majority of the physicians surveyed (57.1%) claimed to spend most of their time in private solo practice, with over half of these (59.3%) employing 3 or fewer employees. In 46% of the cases the only physician in that private practice is the respondent, or him/her and one other physician (80%). This signifies that in essence Puerto Rican physicians work in a profession where the majority are in smaller practices with no more than three employees of which one is a physician. This makes, then, a group most relevant to study as a way of learning more about service/professional services marketing in general and particularly in the smaller enterprise.

The study revealed that there appears to be a shift in physicians' opinions towards marketing in general (section 5.2.3.1), understanding what marketing is (section 5.2.3.2) and the role of marketing in the medical profession (section 5.2.3.3). The indication is that this shift is likely to continue, increasing the understanding of marketing, presumably leading to more use of the various marketing techniques currently used only in a limited way (section 5.2.3.4). In terms of the issues related to the public vs. private sector health services (section 5.2.3.5) and health reform in Puerto Rico (section

5.2.3.6), physicians showed a most consistent opinion, with little shift in opinion over the past 20 years.

When compared with the literature (Korgaonkar 1985, Kotler 1994) the sampled physicians appear to have a good understanding of what marketing is. Physicians agree with the "marketing concept" per se and more so as it relates to their practice of "understanding patient needs". Apparently, despite the shift towards being more in agreement with marketing, those interviewed still believe marketing to be about advertising. This could signify a paradox, physicians are mostly in agreement with the marketing concept in general (being customer oriented), and how it relates to their own practice (being patient oriented) and yet do not fully agree with marketing their profession, as they continue to equate marketing with advertising. Forty three percent did not undertake marketing for their practice. Those that described the type of marketing practice performed, indicated the most important practice was how well the physician performs the service, followed by the role played by staff at the practice. This points to the "part-time marketer" concept advanced by Gummesson (1987, 1990) in that all that come in contact with the customer are responsible for marketing and have an impact on the satisfaction level of the service encounter.

The conclusion is that the use of marketing techniques amongst physicians in Puerto Rico is limited as they prefer to emphasise managing service quality effectively and maintaining a focus on the personal and unique nature of the physician-patient relationship. This can not be construed as a lack of interest, lack of understanding of marketing nor of the practitioners not being market oriented. What it probably suggests is that physicians want to concentrate their efforts on the basis of quality service and the patient-physician relationship.

All of this is in strong agreement with the literature regarding the relationship marketing concept within the area of services marketing (sections 2.4 and 2.4.4). The high degree of agreement found in



this research with the concept of relationship marketing suggests this to be even more important for professional service providers, such as physicians, particularly when the service is conducted in the setting of the smaller firm. Thus, the findings from the analysis of the questionnaire suggest the need to investigate why the physicians-patient relationship is so highly valued and what implications this has on the marketing of the medical practices. This matter, therefore needs to be explored in the case studies.

The findings show that for the most part the attitude of physicians about the statements is not related to the "gender" variable nor the "years in the profession." The variable where most relationship was found was "level of agreement with marketing." As for the model utilised as the general framework for the research, the findings raised questions about its lack of adequacy to explain the behaviour of small professional service firms towards marketing. Based on the particular issues obtained from the analysis of the questionnaire, together with the literature review, a series of research questions were identified to be investigated in the case study analysis.

In summary, the findings indicate that service/professional services marketing has been making significant inroads after the elimination of the traditional restrictions of marketing/advertising on the professions. This is particularly evident as physicians appear to embrace a customer orientation for their practice. The actual use of marketing techniques, nevertheless, appears to remain underutilised.

What physicians understand by marketing, what they do to market their practice, how they go about it and why they market or fail to market their practice are issues that are addressed in chapter six where the analysis of the qualitative survey is presented.

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## CHAPTER 6

### ANALYSIS OF QUALITATIVE SURVEY

#### 6.1 INTRODUCTION

The research methodology outlined in Chapter 3 explained the need to conduct qualitative research, via case studies, to help clarify the concepts that emerged from both the literature review (phase one) and the analysis of the statistical survey (phase two), and to further evaluate the model for marketing in small professional service firms (figure 2.3) utilised as the general framework for the research. The aim of the qualitative research is to provide explanations to key findings of the statistical survey and the literature review in order to facilitate the understanding of the attitude and behaviour of professional service providers in regards to marketing their small firms.

The analysis of the qualitative survey attempts to better understand how the service provider (who is also the business owner in these small professional service enterprises) goes about deciding, implementing and monitoring marketing strategies over the life of the professional practice. The objective of this part of the research is to examine marketing in small professional service businesses by studying, in some depth, the attitudes and practices of physicians in Puerto Rico. The primordial objective is to explain the "why" of the findings in the statistical survey, (reported in chapter 5) to determine the "how" and "why" questions of the physicians' level of agreement with marketing and how marketing actions are decided and implemented, and to describe or examine the real-life context of the physicians.

The research questions to be examined in the chapter via analysis of the case studies are:

Why physicians place an important emphasis in the physician/patient relationship and what implications this has for marketing small professional service firms.

Why are marketing techniques utilised in a limited way by physicians.

Why physicians do not move into the various stages of marketing development as the number of years the physician is in practice increases.

Why agreement with marketing is not increasing as the service provider becomes more experienced in running his/her practice.

What impact does the external and internal environments have, over time, in the practice and what are the implications for marketing.

The process for the selection of the cases, detailed in section 3.4.4.3, resulted in eight cases that were investigated (see table 3.2, chapter 3). Each case was studied separately. Then, cross-case tabulations were used to examine how one case relates to another to reveal differences or similarities and patterns in the level of agreement of physicians towards marketing their private practices, the aspects of marketing they undertake or fail to undertake, and how these are planned, carried out and evaluated.

## **6.2 RESEARCH FINDINGS**

Individual semi-structured interviews of approximately two hours' duration were conducted from February to May 1997, utilising the "aide memoire" (appendix 3) prepared to guide the interviews. The findings presented include the type and size of the practices (section 6.2.1), the "level of agreement" with marketing (section 6.2.2), what physicians understand marketing is (section 6.2.3), the actions physicians undertake to attract and retain patients (section 6.2.4), their process for deciding, implementing and monitoring (section 6.2.5), the physicians marketing system (section 6.3), and the characteristics of the service provider (6.4).

### **6.2.1 Type and Size of Practice**

Table 6.1 below lists the number of locations, years in private practice, number of physicians, number of employees in each of the eight cases studied. The number of employees in all cases



(excluding the physician) is six or fewer in contrast with the statistical survey (table 5.3) where 50.5 percent of those surveyed employed five or fewer, and 64.9% employed ten or fewer. All the practices studied had one physician, with case 8 having two physicians working half-time each at the practice- making it the equivalent to one full-time physician. In the statistical survey, (chapter 5) in comparison, 24.2 percent of all practices employed only one physician (themselves), while 23.2 percent employed one physician additional to themselves (table 5.4).

Table 6.1: Contextual and Descriptive Variables of Cases Studied

Case	Locations	Years in Private Practice	Activity Sector	Physicians	Total Personnel	Net Personnel
1	1	4.5	Secondary	1	5	4.5
2	2	16	Primary	1	6	3.5
3	1	36	Primary	1	2	1
4	1	17	Secondary	1	5	4.5
5	1	4	Primary	1	1	1
6	1	2	Secondary	1	4	2.25
7	1	30	Secondary	1	3	2
8	1	14	Primary	2	6	5

Years in Private Practice is not equivalent to years as a Physician (ie. case 5 has been a Physician for 14 years- four of them in private practice; case 6 has been a Physician for 9 years- four of them as a surgeon and two in private practice).

Total Personnel = all persons available to work for the practice, including spouses of Physicians in cases 1, 2, 4, 6 who assist part-time in administrative functions. Outside professionals hired are not included (ie. accountants).

Net Personnel = number of full time equivalent persons available to work for the practice.

Case 2 operates one location full time and a second location one day a week.  
Case 8 has two physicians each working half time- equivalent to one full time physician.

It is important to point out that there was a rich variety amongst the physicians and their practices. Some was by design, such as the mix of primary and secondary physicians, but the most variety came from the resultant cases themselves, as can be appreciated from table 6.1 below, which shows the years of experience in private practice ranging from two to thirty six, and numbers of employees ranging from one to six.

Appendix 22 provides an edited transcript of the most relevant aspects of the interviews for the eight cases. From the appendix the other variations in the cases under study are depicted. These include a solo practitioner that previously was part of a five physician group practice- all in the same specialty, now a solo practitioner that shares some of his operational costs and staff with another physician from another specialty (case 7). A solo practitioner that shares office space with another health professional- but does not share staff (case 4). A solo practice recently initiated by the youngest physician interviewed after leaving a practice where he shared costs with other solo practitioners which were not interested in "*aggressively pursuing marketing actions*" to develop the practice (case 6). The rich variety of experiences, situations and outlooks from the eight cases studied provide a wide range of perspectives for analysing the "why" and "how" questions aimed for in this phase of the research, thus allowing the explanation of the patterns uncovered in the statistical survey (chapter 5). The analysis of the cases also allows for the further comparison of the findings with regard to the general framework utilised for the research (figure 2.3).

### **6.2.2 Level of agreement with marketing**

The questionnaire utilised in phase two (appendixes 1 and 2) was administered to each of the eight physicians selected for the case study at the beginning of the interview. Utilising the same methodology of the statistical survey (phase 2) for the "level of agreement with marketing" variable (sections 3.4.3.6 and 5.2.3.3), the responses of the eight physicians were analysed. The results of the eight cases is the same as that obtained from the survey of 105 physicians (phase two). In the majority of the cases (6 or 75%) the physician is "neutral about marketing" (similar to the 75.2% of the physicians in the survey) while a minority is "strongly in agreement" or "strongly in disagreement" (one each or 12.5% each) (similar to the 9.5% of

physicians surveyed in phase two the who “strongly disagree with marketing” and the 15.2% who “strongly agree with marketing”).

Table 6.2 below shows that case two was the only physicians who, based on his responses, was classified as “strongly in agreement with marketing”, while case 4 was the only physician classified as “strongly in disagreement with marketing”.

Table 6.2: Sample Classification in Terms of Attitude to Marketing

Region	Physician Classification	GROUP I Physicians that advertised	GROUP II Physicians that did not advertise
Region 1: with most physician advertising (4 cases)	Primary Physician	Internal Medicine neutral about marketing (case 5)	Internal Medicine strongly agree with marketing (case 2)
	Secondary Physician	Ophthalmologist neutral about marketing (case1)	Ophthalmologist strongly disagree with marketing case 4)
Region 2: with the least physician advertising (4 cases)	Primary Physician	Family Physician neutral about marketing (case 3)	Family Physician neutral about marketing (case 8)
	Secondary Physician	Surgeon neutral about marketing (case 6)	Surgeon neutral about marketing (case 7)

It is interesting to note that all of the cases that advertised (Group I) are “neutral about marketing”, thus if a physician advertises it does not necessarily mean he/she is in strong agreement with marketing. Likewise, if a physician does not advertise, it does not mean he/she is not in strong disagreement with marketing as some are “neutral” (cases 8 and 7) while others

were categorized as “strongly agree with marketing” (case 2) and “strongly disagree with marketing” (case 4). Further explanation of this is presented in section 6.2.3 where the cases are analysed in terms of what physicians understand marketing to be, and in section 6.2.4 where the analysis of cases is presented in terms of the actions physicians undertake to attract and retain patients.

### **6.2.3 Understanding of Marketing for their Practice**

The analysis of the cases (table 6.3) below shows that physicians mainly understand marketing to be advertising, selling (via advertisements). This is in agreement with the findings from the statistical survey (section 5.2.2.2) whereby physicians’ responses supported acceptance of the hypothesis that *“marketing is mostly advertising and promotion”*. This limited definition of marketing explains why some physicians do not want to use marketing (cases 4, 7, 8), since they equate it to advertising and do not agree with its use for their practice, and why others use it with hesitation (cases 1, 5). The issue of ethics, which is discussed in section 6.2.4 below, comes into play in the physician's definition of marketing, as some cases (1, 3) note their advertisements are ethical because they are not *“commercial”*.

The limited view about marketing, summarised in table 6.3 below, has to do with the “formal definitions” of what physicians believe marketing is. The in-depth interviews conducted allowed for an analysis of the actions they undertake (or fail to undertake) in their practice and the reasons why. The analysis of the cases shows physicians in solo practice to be mostly patient centred, placing the physician/patient relationship at the centre- the focus of the way they go about running their practice. This is in agreement with the findings of the statistical survey (section 5.2.2.4), whereby physicians’ responses supported acceptance of the hypothesis related to the physician/patient relationship being *“personal and unique, and should not be established as a result of pressures exerted by marketing techniques”*.

Table 6.3: Physicians' Definition of Marketing

Case	Physicians Definition of Marketing
Case 1	<i>"marketing is embellishing the (patients') senses to inform the public"</i>
Case 2	<i>"marketing is the way you project yourself in the community so they utilize your services"</i>
Case 3	<i>"marketing is a system for you to promote a service to be offered"</i>
Case 4	<i>"the good aspect (about marketing is that) you can use it to educate... but in our society, marketing many times results in commercialization, business, multiplying income and not much about multiplying services or reducing the costs of services"</i>
Case 5	<i>"marketing is almost always like promoting some services. This takes place via different methods, basically print and television"</i>
Case 6	<i>"marketing is to make available a service that satisfies a consumer, to provide it in a way that (the consumer) is satisfied (pleased with the service)"</i>
Case 7	<i>"marketing is to make yourself known in the community, advertise more, make surgery more attractive... that the patient is comfortable..."</i>
Case 8	<i>"marketing is selling...presenting t.v. ads, advertising what I do, visiting industries to sell my product, what I do, to persons that have the need for this type of (medical) practice"</i>

The statistical survey (section 5.2.2.2) also highlights physicians' responses supported acceptance of the hypotheses about agreeing with the basics of the marketing concept (Kotler 94) in general terms (being customer centred) as well as for their profession (being patient centred). Many of the physicians, however, do not necessarily see this as marketing, possibly because of the "definition" they advanced of marketing (table 6.3). Similarly, many physicians mentioned they hardly perform marketing functions, when, as section 6.2.4 discusses, they are most conscious of how patients learn about their practices, and why they continue visiting them and act accordingly. Again, the reason for this appears to be their limited "definition" of marketing. It is appropriate to mention, thus, that according to the cases studied, most physicians appear very genuine in their belief about the importance of being patient centred and the emphasis they place on the physician/patient relationship. It is done, it might be argued,

because it is their nature to do so rather than because they understand it is an appropriate commercial decision to undertake. Yet, their "informal" measurement process, discussed in section 6.2.5, confirms that the focus on the patient produces results in terms of attracting and retaining patients (section 6.2.4). The analysis that follows of what physicians believe attracts and retains patients for their practices, indicates that physicians appear to have developed an instinctive understanding of marketing.

#### 6.2.4 Actions to Attract and Retain Patients

The physicians studied were asked to provide their views on how patients learn of their practice and why they return. Appendix 23 details how the physicians interviewed responded. Table 6.4, below, summarises the main themes identified from the cases.

Table 6.4: Main Themes Identified of How Patients Learn of the Practice and Why they Return

THEME	CASES	% RESPONSE
Physician/Patient relationship	1, 2, 3, 4, 5, 6, 7, 8	100
Word of mouth	1, 2, 4, 5, 6, 7, 8	87.5
Referrals	2, 5, 6, 7, 8	62.6
The role of staff at the practice	2, 4, 5, 6, 8	62.6
Advertising	1, 3, 5, 6	50
Patient satisfaction	5, 7	25
Recognition of the physician within the community	3	12.5
Particular type of specialty of the physician	7	12.5

The analysis of the cases (table 6.4 and table 6.1) shows that word of mouth is used in 87.5% of the cases, which includes physicians in all ranges of years in private practice. This appears to be in disagreement with the Model for Marketing in Small Professional Service Firms (figure 2.3) utilised as the general framework for this research. The model, following the Carson Model (1985, 1990, 1993) (figure 2.2) places word of mouth as a key marketing

function of the small firm specifically in the early development of the firm (stage 1). The model further proposes that advertising is undertaken first at stage 2 ("occasionally"), evolving to be carried out more "professionally" in stage 4. The findings of the case analysis, again, appear to be in disagreement with the model as advertising was utilised by all three of the physicians in the early stage of developing their practice (case 1 with 4.5 years in private practice, case 5 with four years in private practice, and case 6 with two years in private practice). Additionally all physicians in the mid range of years in private practice, cases 2, 4, and 8 (14 to 17 years in private practice) did not advertise. This is in agreement with findings of the statistical survey (section 5.2.3.2) which also differed with the model utilised as the general framework for the research, as years in the profession was found not to be related to the attitudes or behaviour of the physicians surveyed.

As might be expected the four cases that were selected because they advertised in their respective regional newspapers (cases 1, 3, 5, 6) represent all of the cases that indicated patients learn of their practice because of their advertisements (table 6.3, above). Case 5 was the most emphatic that patients learned of the practice because of the advertising. Case 1 indicated advertising helped initially as the practice got started, but suggested that most patients now visit because of word of mouth. Case 3 uses advertising particularly to inform potential patients of the house visit service (unique in the region) while Case 6, on the other hand, places the advertisements with the objective of attracting patients whose private health plans allow for free physician selection. All of the cases that advertised identified the physician/patient relationship as a primary reason for patients to return to the practice and to recommend it to others. Physicians that advertise believe its use is mostly to inform the public of the practice, not as "*commercial advertising*" to "*sell*" the practice, an action described by case 1 as putting forward his "*presentation card*" (with his name, specialty, location, hours of operation) in the regional newspaper.

It is appropriate to mention that the physicians that do not advertise believe the advertisements of their colleagues to be "*commercial*" in nature, and unethical. One of the physicians with most years in practice (case 7) summarises it best:

*"[before] physicians did not advertise [because] it was felt it was not ethical that physicians advertised as it was a matter of commercialisation ... but now-a-days [physicians are advertising] and patients are being called clients"*

Three of the four physicians that advertise (cases 1, 3, and 6) see their action as informing the public. One of the physicians that advertises (case 5) is considering eliminating the advertising, despite her understanding that it results in attracting patients to her practice, because she is uncomfortable with the ethics issue. Interestingly, the case that pairs it (case 2) understands it is inevitable that he (reluctantly) will need to advertise shortly. This type of uncertainty of how to deal with the issue of ethics is perhaps best explained by case 1 who does place advertisements, but is quick to argue that they are not ads because "*it is not sophisticated, is not promoting for people to come, it is simply a formal invitation to allow me to be known*", they are not placed, he suggests "*with the purpose of promoting to get patients in...*". Rather he regards his advertisements as putting forward his "*presentation card*" in the regional newspapers, an action triggered after seeing it done by other physicians in his specialty within the geographic area of his practice. Similarly, case 3 explained his advertisements as "*not a commercialised ad [which would mean saying] we are the best, we are unique, no one is better than us ... because those ads are not ethically accepted*".

The apparent tension amongst the cases studied with the issue of advertising, is related to the forces of the external environment where these service firms operate (chapter 4). Competition, as explained in chapter 4, is growing (by design of the health reform programme underway), and the elimination of restrictions that banned marketing activities (including advertising) has resulted in some practices undertaking marketing activities. These examples of external



environment issues appear to collide, to a certain extent, with the decisions a professional service provider can undertake related to his/her internal environment. This matter is further explored in section 6.3.

Further review of the cases suggests a close interrelationship amongst the themes that physicians mostly identified as the reason patients learn of their practices and return (table 6.4). The positive physician/patient relationship, together with the role of staff at the practice, for example, provided for the type of service encounter that would lead to satisfied patients that recommend (word of mouth) the practice to relatives, friends and neighbours. Likewise, such positive word of mouth recommendation has an impact on the physician's patient referral system, as discussed in section 6.3. This is supported by Kotler 2000 (p. 436) as "*... service consumers generally rely on word of mouth rather than advertising*". This is in agreement with Zeithaml (1981) who contrasts the importance customers place on personal sources of reference (such as word of mouth) for services vis-a-vis for goods, where non-personal sources of reference (such as advertising) are likely to play an important part in the decision-making process. Zeithaml further establishes that among those services high in credence (such as medical diagnosis), the use of word of mouth is of significant importance in the customers' decision-making process, as evaluation is most difficult even after the utilisation of the service, since the customer is unlikely to have sufficient knowledge to determine if the service was properly performed. The lack of interrelationship, from the physician's point of view, of advertising with the other areas they identified as critical to attract and retain patients (mainly physician/patient relationship) is one explanation of why some do not use and do not plan to use advertising in the future (ie. case 4) and why most of those that use advertising (cases 1, 3, and 5) caution that its use is to inform rather than to attract patients.

The positive physician/patient relationship unanimously identified as a major reason of how patients learn about the practice and return (table 6.4), was mostly equated by the physicians with the quantity and quality of time spent with the patient in the process of examination- the questions asked, the care shown for the patient's concerns and the humane treatment of the patient. The importance of the physician/patient relationship, as detailed in section 6.3, is the focus of the physician marketing system, and serves as the basis for many decisions of the physician, as explained in section 6.2.5 below.

#### **6.2.5 Deciding, Implementing and Monitoring Process**

Analysis of the cases shows physicians in solo practice making decisions on all aspects of the practice. These include staffing, placing or not placing advertising, medical plans to accept or to reject, when and how to make referrals to other physicians or health professionals. In the practice with two physicians, each working half time (case 8), both share the responsibility of making decisions, but one of the two is the managing partner because "*...he is the one with an administrative mentality ... has the personality [for negotiations], is more aggressive, assertive, and negotiates until the very end*". Half of the cases (cases 1, 6, 7, 8) mentioned the use of outside professionals on aspects related to the administration of the practices. The outside professional was a Certified Public Accountant (CPA) or someone specialised in the billing process. Their role included accounting (case 1), special analysis to audit the practice (case 8), day-to-day administration of the practice and advice on investments (case 7), and billing service and monitoring the performance of the practice and staff (including the physician) vis-a-vis standards set by the physician (case 6). None reported utilising outside professionals for the marketing activities. This does not support the notion advanced in stage 4 of the model used as general framework for the research, whereby outside marketing expertise is hired to achieve desired growth.

Half of the cases (cases 1, 2, 4, and 6) reported the involvement of the spouse in practice administration. The reasons included the physician wanting to share with his wife responsibility of the administration (case 6), the physician's absolute dislike and lack of desire to get involved in administration (case 4) and the spouse's interest in undertaking such a function (cases 1 and 2). None of the physicians interviewed whose spouse is involved in the practice referred to them as "employees", all describing their role on a part-time basis either at the practice, from home or both.

All cases reported a decision-making, implementing and monitoring process that is mostly informal, based on direct, personal communication with patients, staff, spouse, outside professionals, and other colleagues. Examples include information patients provide in the records (ie. why they visit the physician) (case 1) or in the evaluation with the physician (case 5), when the flow of patients diminishes (including changes in the pattern of referrals) the physician *"looks for a logical explanation"* (case 2).

The one exception to the informal process carried out by the other seven cases studied is case 6 which requested that someone he hired to do the billing for the practice to maintain reports and statistics. The physician, in consultation with the staff at the practice, developed a set of performance standards to audit the performance of each employee as well as himself. Formal meetings of the physician and his wife with the billing agency are conducted monthly, decisions are made by the physician based on the analysis of the information and the physician later meets individually with the members of his staff to share the results of the audits. The physician explained that the audits show his shortcomings:

*"...because [he] was not trained to (run a) business and it is very difficult (to get) a business/physician mentality and that is how everything gets defined (in this new era of health care management)...I evaluate my practice from the point of view of a business and this is like a business, unfortunately. Within (that reality) you have to provide a humane service and all of that, but you need to have controls..."*

The need to have this type of data available to run a medical practice effectively has encouraged the physician to use his computing skills to develop software which he is testing at his practice. The physician plans to commercialise this software via a separate business entity he has started with his brother and with the Oracle software corporation as a strategic partner. It is appropriate to highlight that the physician is "*directing the practice to be patient centred*" and has hired the billing agency to do that function outside the premises of the practice in order for the staff to maintain a focus on the patients at all times.

Notwithstanding their informal manner of operating for most of the cases, all physicians appeared to have a good indication of how the practice was going and were generally satisfied with its development. The frame of reference upon which they evaluated and took decisions is directly linked to their personal set of values, interests and attitudes. Cases 4 and 8, for example, were preoccupied that their practice would grow too much/too fast and, in the process, "*would get out of their hands*" (out of their control) and, as a result, adversely affect the physician/patient relationship. Similarly, the health reform underway in the region was not well received in all cases, mostly because physicians saw it as increasing the number of patients, thus reducing the time available to see them and resulting in an adverse impact on the physician/patient relationship. This apparent tension caused by the possible impact of the external environment on the day to day operations of the practice (the internal environment) is further explored in section 6.3.

This analysis points to solo practitioners with an informal *modus operandi*, deciding, implementing and monitoring actions based on what they understand is best for their practice. The frame of reference, what they are in agreement/disagreement with, what initiatives to pursue to get more patients vis-a-vis to limit the growth of the practice, is very much related to the reason they are in private practice to begin with: to decide for themselves what is best (in

their opinion) for the physician/patient relationship and to act accordingly. In this sense, the physicians studied appear to be very much like most small owner/manager businesses, indeed half of them are like family businesses, deciding what is best for the practice guided by their own set of personal motivations and beliefs. What they believe is best for the physician/patient relationship appears to explain best the physicians' marketing system, as the next section discusses.

### **6.3 THE PHYSICIAN MARKETING SYSTEM**

Prior to this qualitative survey the researcher wanted to be able to have multiple variables upon which to measure the findings. The methodology previously explained thus took into account several external and internal variables: the region where most/least physicians advertised, the classification of physicians (primary/secondary), and the action of advertising /not advertising in regional newspapers.

The analysis of the cases studied appears to indicate that the issues that answer the "why" and "how" questions are not strongly impacted by the geographic region, nor by the practitioner classification (primary/secondary), nor the marketing actions (such as advertising) that they perform or choose not to perform. The analysis of the cases indicates that all physicians understand and practice a market orientation as they value and place special emphasis on the physician/patient relationship. It is precisely this strong concern for developing and maintaining the physician/patient relationship that is the one common denominator for all physicians for the marketing actions they perform or fail to perform. Notwithstanding this fact, as previously explained, some do not see this as marketing.

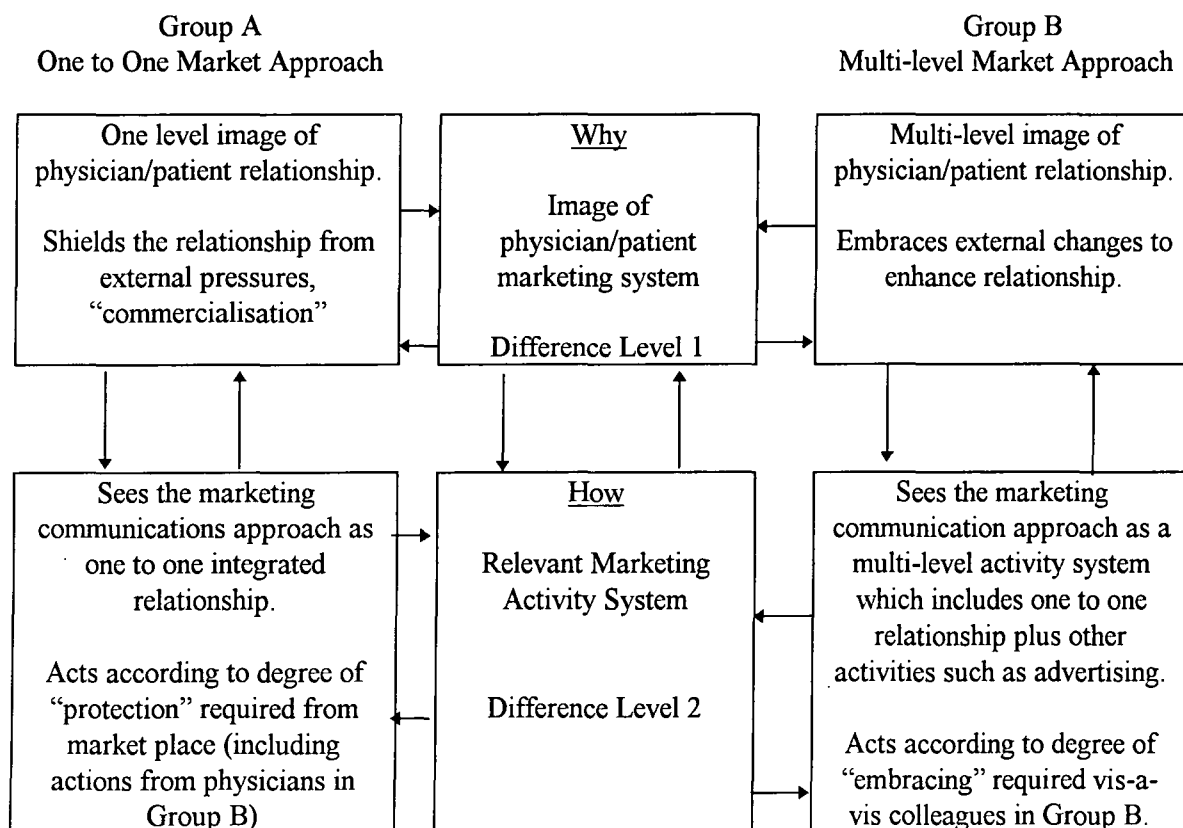
All of the physicians studied, without exception, favour and cherish a good physician/patient relationship. According to this research, that is why some “market” their practice. The research shows that the physicians that use, as well as those that fail to use, marketing activities, do so based on their understanding of how such activities (or lack of activities) enhance the physician/patient relationship. The apparent tension between the possible impact of the external environment with what the service provider understands is best for running the practice (the internal environment) has resulted in an interaction between core issues relevant to the physicians studied. How they manage such interaction has led to the classification of the physicians studied into two groups:

**GROUP A - One to One Market Approach** - This group of physicians understands that the best way to be patient (customer) oriented is to shield or protect the relationship from the “*commercialisation*” process that is being brought about by the changes in the external environment. These physicians see the changes (such as the health reform, and the increased use of marketing activities by colleagues) as adversely affecting (to a greater or lesser degree) the physician/patient relationship and act accordingly. They consider that their best marketing approach is the one-to-one relationship.

**GROUP B - Multi-level Market Approach** - This group of physicians understands that the best way to be patient (customer) oriented is to keep up with the times and thus embrace the changes in the external environment. These physicians see the changes in the external environment (such as the health reform and the increased use of marketing activities by colleagues) as positively impacting (to a greater or lesser degree) on the physician/patient relationship and act accordingly. They consider that their best marketing approach is a multilevel activity system which includes one-to-one relationships plus other activities, such as advertising.

Figure 6.1, below, provides a summary of the linkages of the “why” and “how” questions this phase of the research has sought to answer. Why marketing actions are undertaken (or not undertaken) by physicians is mostly determined by the physician’s view of how such actions enhance or affect the physician/patient relationship. At the time of the research, a significant series of changes was taking place in the health care environment in Puerto Rico, thus physicians classified in group A, as well as those classified in group B, disagree/agree to a greater or lesser degree with other colleagues in their respective groups in terms of the level of “protection” or “embracing” that the physician/patient relationship requires. What marketing actions are undertaken or not and how such actions are decided upon, implemented and evaluated is related to the physicians’ classification in Group A (one to one market approach) or Group B (multi-level market approach) as well as their degree of agreement/disagreement with respect to the actions undertaken by colleagues in both group A and B.

Figure 6.1: Physician Marketing System



As Figure 6.1 indicates there is a "difference level 1" and "difference level 2" among physicians in groups A and B in terms of explaining why each group views the physician/patient relationship differently and in how this impacts on how particular actions are taken (or not) by physicians. The research indicates there is a growing gap between the difference levels amongst physicians in group A and those in group B.

At the "difference level 1" stage, for example, physicians in group A are most concerned with colleagues in group B who they understand have changed the physician/patient relationship to be one of physician/client giving way to a "commercial" relationship which they understand is completely unwarranted in the professional services setting, particularly in the field of health services. This difference level appears to widen as physicians in group B undertake marketing actions such as advertising, thus further reaffirming for physicians in group A the displeasure and energetic disapproval of *"changing the physician/patient relationship to one purely based on commercialisation to a physician/client relationship"*. Physicians in group A react to the actions of physicians in group B by further reaffirming their belief that the physician/patient relationship is best attained and maintained by shielding the relationship from the emerging "commercialisation" process that is taking place in the external environment in which they operate.

Physicians in group B, on the other hand, understand that the physician/patient relationship is enhanced as they incorporate into their practice the changes that are taking place in the health care marketplace. Physicians in group B understand that physicians in group A are excessively conservative and take exception to the actions undertaken by physicians in group B because they are out of touch with the changing times and, sooner or later, will need to adapt in order to attain and retain an effective physician/patient relationship. Physicians in group B are more



concerned with the actions undertaken by other physicians in group B to attract and retain patients.

Physicians in group B are mostly impacted by the activities of their peers in group B. Some physicians in group B will initiate a particular action (i.e. aggressive advertising in regional newspapers) while others in group B concede they would rather not initiate such action but will monitor such developments by colleagues in the same medical specialty and geographic market. This exemplifies a very important interaction among the external environmental factors and the individual factors of the physician operating in a solo practice. The findings of this research are in agreement with Davidsson and Wiklund, 1999; and Child, 1972 who argue that the owner/manager is free to choose among various strategies to pursue under the same environmental conditions, thus activities they undertake may depend on the external environment, but are not completely determined by it.

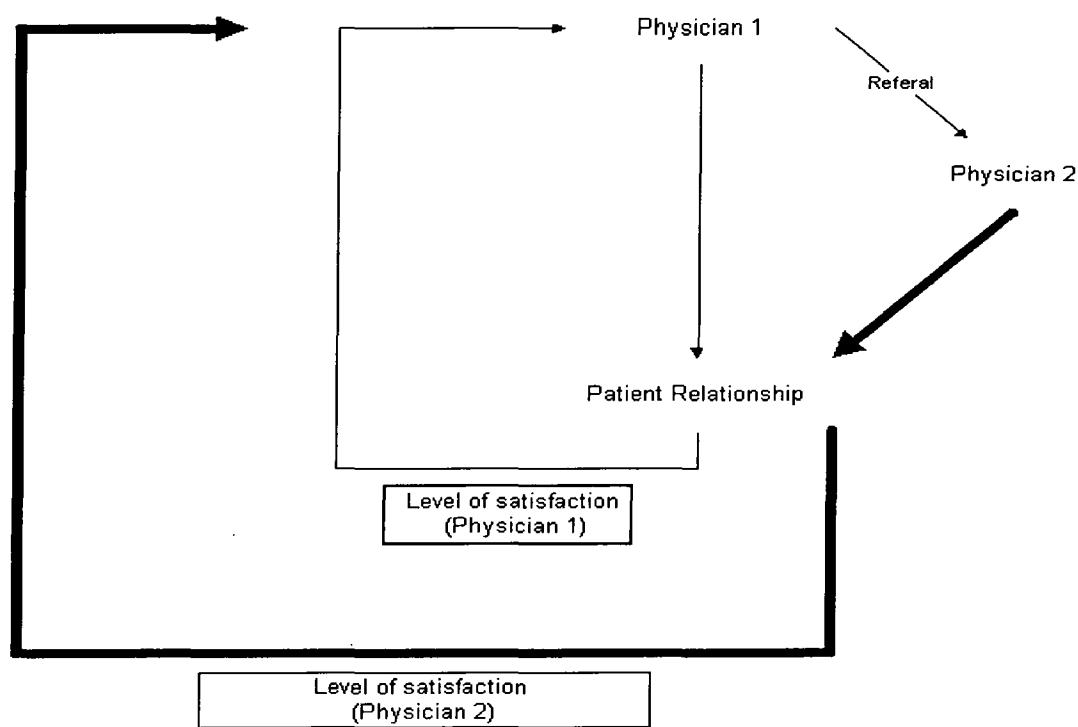
The findings of the case study show that the impact of the external and internal environment on the marketing activities of the small professional service firm are constantly interacting, through the life cycle of the firm. The findings further suggest that, contrary to the model utilised as the general framework for the research (figure 2.3) (whereby the internal environment had a higher impact at the early stages of the firm cycle and the external environment had a higher impact in the latter stages of the firm) both the external and the internal environments have an impact throughout the life cycle of the firm. This is supported by the findings of the statistical survey (section 5.2.4) which found there was no relationship with the years the physician is in the profession and the indexes for the internal and the external factors studied.

The physician/patient relationship as a core value of the physicians studied is best explained in the context of the process of physicians referring patients to other physicians. Physicians in

groups A and B expressed their concern with the level of patient satisfaction with the other physician as adding to (or taking away from) the level of satisfaction with the original physician. This concern serves as a main criteria for a physician determining to which colleague he/she should refer a patient.

Figure 6.2, below, shows there is a level of satisfaction in the physician/patient relationship as a result of the service encounters with physician 1. Similarly, as the same patient is attended by physician 2 (referred to by physician 1) a level of satisfaction in the physician/patient relationship is produced. The positive or negative level of satisfaction of the patient with regards to the service encounter with physician 2 will enhance or damage the level of satisfaction of this patient with physician 1.

Figure 6.2: Physicians' Patient Referral System



In the process of referring/obtaining referrals to/from other physicians, a physician aspires to be part of a "winning" network which provides adequate care to the patient and the service encounter results in a high level of satisfaction for the patient. The case studies examined indicate the longer a physician has been in practice, the more referral transactions he/she experiences that provide the basis for him/her to assess the level of satisfaction with the medical care received by patients, as well as the level of satisfaction his/her patients experience with the service encounter.

Based on such experience, the physicians interviewed add/delete a particular colleague over time to their options for referral. Physicians that refer to a particular physician appear to do so to maximise the level of medical care and patient satisfaction with the service encounter. Other physicians that share such a concern choose not to refer to a particular physician and will indicate to the patient to choose which physician from a certain medical specialty to visit.

Those physicians that do not refer to a particular physician (a minority of those interviewed) appear to do so to minimise the harm in the physician/patient relationship that may result from a possible dissatisfaction of the patient with the outcomes of the service encounter with the other physician. The findings support the notion discussed in the literature review (section 2.8) of the use by smaller firms of the "personal contact network" as a basis for conducting marketing activities. A key characteristic of the personal contact network, according to the literature (section 2.8) is that the entrepreneur knows the person in his/her personal contact network and that such a personal network operates on an informal basis. The findings further advance the importance placed by the service provider on their long term relationship with a client, based on the level of satisfaction of the service encounter of the client with other service providers that belong to their personal contact network.

The general framework for the research adopted the notion advanced by Carson (1985, 1990, 1993) that the personal contact network was utilised mostly as the small firm initiated operations. The findings of the research suggest that physicians continue to rely, over time, in the personal contact network, as 62.6% of the cases (table 6.4) understand referrals are the key to obtaining and retaining patients. These physicians represent the complete range of years of having been in private practice. Thus, the finding of the case study do not support the model's construct that personal contact networks are utilized mostly in stage 1.

#### **6.4 CHARACTERISTICS OF THE SERVICE PROVIDER**

The literature reviewed (section 2.8.5) indicated the importance of the motivations of the owner of the small firm in the decision process of operating the firm and explained the impact it has on the internal environment of the enterprise. The literature accentuated that in essence the owner's goals equate to the business goals at the early stages of the firm (Churchill and Lewis, 1983; Gibb and Davies 1990; Scott and Bruce, 1987) but, as the company evolves through its life cycle, the need for growth dictates the company's goals. For this reason the general framework for the research incorporated into the Carson model (1985, 1990, 1993) (figure 2.2) the internal environment, particularly as it related to the owner's goals, as having a higher impact in the early stages of the firm. The findings from the statistical survey (section 5.2.4), however, did not support this construct of the model.

The findings of the case analysis suggests that the motivations of the physicians (service providers) appears to be influenced by their personal stage in the life cycle as well as the stage of the life cycle of their practice. This is illustrated in table 6.5 below, which shows the cases studied listed in increasing order of the personal life cycle/practice life cycle.

Table 6.5 below, summarises the analysis from the cases, as viewed from the perspective of the qualitative survey, that points to the intricate relationship between the personal characteristics, motives and influences of the practice owner/manager/service provider and the characteristics of the practice itself. In the setting of the small practice, the way the practice is run, the way the service is provided is decided by the provider of the service (in this research the physician) making his/her personal motives, influences, stage in the personal life cycle to a great extent synonymous with those of the practice.

Table 6.5: Life Cycle, Motivations of Physicians

Case	Personal/Practice Life Cycle	Motivation/Characteristic	Influence
Case 6	young, starting private practice	grow, build practice via marketing/ highly aggressive	a role model at Medical School
Case 1	young, practice in progress	enhance practice/ moderately aggressive	what colleagues in the area do
Case 5	mid life, mid career young private practice	transfer reputation from previous medical experience/moderately aggressive; patient centred	what is best for the patient
Case 2	mid life, mid career	tackling difficult medical cases/ medically up to date but settled on other aspects of practice	changes caused by health reform
Case 4	mid life, mid career	maintain reputation, quality of care/ keep patient volume under control	strong personal standards
Case 8	mid life, mid career	other motivation- teaching at Medical school/ part-time practice to allow it	vocation to teach
Case 7	mature, well established practice	spend more time with the family/ slowing down	age of parents
Case 3	most mature, limited practice	contribute to the community/ high involvement in civic activities	improve quality of life

Motivations of the service provider may change over time, as the personal characteristics evolve. The analysis of the cases shows this to be the situation. For example case 3, the most mature of the physicians, has a limited practice to allow his pursuit of being involved in a variety of civic and community activities. At a younger age (when his children were in university) he maintained two private solo practices in two geographic locations and worked a night shift in a regional hospital. Case 7, now in solo practice and slowing down to spend more time with his family, used to be part of an aggressive group practice (five physicians) in his younger years.

The findings of this research, thus point out that, in the setting of the small professional service practice, the motivations of the service provider have a high impact on the operation of the service firm throughout the life cycle of the service provider. This does not support the model utilised as the general framework for the research, which proposes that the owner's goals and motivations (as part of the internal environment of the firm) have a higher impact in the early stages of the firm's development. As explained, the findings show the owner's goals and motivations have a significant impact throughout the life cycle of the firm. In essence his/her motivations throughout his/her personal life cycle equate to the firm's goals throughout its business life cycle.

Several of the theories of small business marketing (section 2.7) help explain these findings. The research shows physicians in solo practice following the five attributes of small business advanced by Schollhammer and Kurilof (1979), namely: 1- scope of operations (serving predominantly local/regional markets), 2- scale of operations (limited share of a given market), 3- ownership (equity owned by one or few people), 4- independence (not part of another enterprise, owner/manager has ultimate authority and control), and 5- management style (personalized, no general sharing of decision making).

This is further explained by Davis et al. (1985) who support the issue of differences of marketing practices for small firms, namely that small businesses have different marketing objectives (vis-a-vis larger businesses). The findings suggest that the different marketing objectives of small businesses are impacted by the stage of the personal life cycle of the service provider.

The findings do not support the underpinning assumption of growth as the motive of the marketing evolution model advanced by Carson, 1985, 1990, 1993 (section 2.8). Further, the findings do not support the notion advanced by Cannon, 1980 and Churchill and Lewis, 1983 about the attitudes of owner-managers being important elements in the business start-up stage only. The findings do support, however, researchers that propose that the marketing behaviour of small firms is related to the personal characteristics of the owner manager (Ford and Rowley, 1979; Smith, 1967; Smart and Conant, 1994), and that the owner's influence on management decisions is greater in smaller firms (Stash and Ward, 1987). It should be pointed out, though, that the findings do not limit their support to the personal characteristics of the owner-manager in the literature as they include a variety of other characteristics, including the interaction between the external and internal environment described in section 6.3.

Chapter 7 presents the conclusions and implications of the research. In that process of presenting how the findings corroborate/refute the literature, chapter 7 provides further explanations relative to the findings of both the statistical survey and the qualitative case studies.

## 6.5 SUMMARY

The analysis of the cases shows solo practice physicians to be mostly patient-centred, placing the physician/patient relationship at the centre- the focus- of the way they go about running their practice. Many of the physicians, nevertheless, do not necessarily see this as marketing. Similarly, many physicians mentioned they hardly perform marketing functions when, in fact, they are most conscious of the various reasons why patients learn about their practices and continue visiting them.

The physicians studied show that this group understand and practice a market orientation as they value and place special emphasis on the physician/patient relationship. Physicians differ in how they understand it is best to enhance the physician/patient relationship and this explains what actions they do (or fail to do) and how these are carried out.

The cases studied show that what the physician does to market his/her practice is determined by the orientation of the physician as to how best to enhance the physician/patient relationship. Other variables such as the region where they operate, the type of physician classification (primary/secondary), among others, do not appear to have a major impact on why marketing actions are undertaken (or not ).

Physicians that understand that changes in the marketplace adversely affect the physician/patient relationship act in a manner consistent with protecting this relationship from the outside "*commercialisation*" pressure. Physicians that understand change in the marketplace as positively impacting on the physician/patient relationship act in a manner consistent with embracing such changes.



Both groups of physicians agree on the importance of attaining and maintaining the best possible physician/patient relationship. Both groups also understand that in their solo practice they have the control to act according to what they understand enhances the physician/patient relationship. Thus, those physicians that believe the best way to enhance the physician/patient relationship is to resist external "*commercialisation*" pressures, act accordingly. Likewise, those physicians that view external changes as positive, embrace them as a way of enhancing the physician/patient relationship.

Thus, the findings of the cases studied show that the impact of the external and internal environment on the marketing activities of the small professional service firm are constantly interacting, throughout the life cycle of the firm. The findings do not support the Model for Marketing in Small Professional Service Firms (figure 2.3) utilised as the general framework for the research, as the analysis of the cases shows both the external and the internal environments having an impact throughout the life cycle of the firm, thereby supporting by the findings of the statistical survey (section 5.2.4), which found there was no relationship with of the years the physician has been in the profession and the indexes for the external and internal factors studied. The findings further suggest that the owner's goals and motivations (part of the internal environment of the firm) have a significant impact throughout the life cycle of the firm (section 6.4). Thus, in essence, the motivations of the owner throughout his/her personal life cycle equate to the firm's goals throughout its business life cycle, contrary to what the model (figure 2.3) advanced (that owner's goals and motivations had a high impact only in the early stages of the firm's development).

Studying physicians in solo practice allows the opportunity to examine the marketing/entrepreneurship interface amongst professional service providers that are basically non marketers and non entrepreneurs, but are being impacted by the changing external

environment to become more enterprising and marketing oriented. The findings of this research show relationship marketing as the core of the marketing/entrepreneurship interface in small professional service firms. This is in agreement with Cromie and Carson (1995, p. 590) who argued “... *that relationship building and maintenance is a crucial aspect of the work of entrepreneurs and marketers.*” The analysis of the cases greatly supports the notion of relationship marketing as being particularly appropriate for service firms. This is best summarised by Grönroos (1995, p. 252) who suggests that “*Service firms have always been relationship oriented. The nature of service business is relationship based.*” This contrasts significantly with successful firms in the industrial sector with rapid development. According to research by Raffa and Zollo (1995) such firms are not necessarily customer driven, but rather driven by technological innovation.

Perhaps the fact that physicians in solo practice were studied explains the level of control they are aware they have over decisions and actions in their practice and the fact that they exercise such control. Physicians in the solo (or small) practice are the service providers as well as the owner/administrator/marketer of the practice, thus having much control over the variables affecting the physician/patient relationship. This particular situation in the smaller professional service practice enhances the definition of relationship marketing advanced by Gummesson (1996, p. 81) as marketing “... seen as relationships, networks, and interaction”, departing from “transaction marketing” (Grönroos, 1995, p. 253; Gummesson, 1996, p. 88-89).

The physicians studied appear to understand the benefits to their practices of retaining patients, supporting the findings of Reichheld and Sasser (1990) across a variety of service industries. They also know that all employees have an important role to play in enhancing the relationship with the patient, thus showing an understanding of the “part-time marketer” concept introduced by Gummesson (1981, 1987, 1990) and advanced by Grönroos (1990a, 1990b) regarding the

critical marketing role performed by employees who come into contact with customers in service organisations.

The growing changes in the health care environment in the area under study, (such as the implementation of the health reform in all Puerto Rico, the role of primary physicians as gatekeepers, the increase in marketing actions such as advertising by other physicians) point to a growing gap between how physicians believe such changes damage/enhance the physician/patient relationship; and a growing gap among physicians in both groups A and B, with regard to the level of damage (thus the need for a certain level of protection) or the level of enhancement (thus the need for a certain level of embracing) of the physician/patient relationship.

This research has dealt with the perspective of the service provider. An area for further study, explained in Chapter 7, is the perspective of the patient- where the literature (Berry, 1995) points out that relationship marketing benefits the customer who ultimately desires "... continuity with the same provider, a proactive service attitude, and customized service delivery" (Berry, 1995 p. 237).

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## CHAPTER 7

### SUMMARY CONCLUSIONS AND IMPLICATIONS

#### 7.1 INTRODUCTION

The emergence of the service sector and its growing importance is a worldwide reality as services account for the majority of the total worldwide GNP. The deregulation of the service industries in the 1980s removed the barriers that had shielded many of these industries from an increasingly competitive environment. Similarly, the lifting of the restrictions on advertising and certain other marketing practices by the professions combined to create a significant pressure for all types of professional service firms to consider seriously the role that marketing could have in their businesses.

The literature reviewed (chapter 2) shows the professions traditionally viewed marketing as not appropriate for their practices with many small service firms not engaging in marketing because they thought that the use of marketing was unnecessary (Kotler 1991 and 1994). This is particularly true for health services marketing which has lagged behind services marketing (Kotler and Clarke, 1987). The literature of small firm marketing is limited despite the significant impact of small businesses in the economy (Davis and Klassen, 1991) thus resulting in an absence of appropriate small business marketing theory. The general framework to conduct the research, based on the literature reviewed (section 2.8), is the Model for Marketing in Small Professional Service Firms (figure 2.3) which incorporates both the external and internal environment to Carson's Model for Development of Small Firm Marketing (1985, 1990, 1993) (figure 2.2).

This research examines the perceptions which small professional service providers have about marketing. A combination of quantitative (survey) and qualitative (cases) research techniques

(chapter 3) have been utilised to determine what practitioners understand by the concept of marketing, the extent to which they adopt a market orientation, why they agree/disagree with the use of marketing, why they do or do not undertake marketing activities and how these are determined, implemented and monitored.

The group of professionals studied and the area under study (physicians' services in Puerto Rico) was most appropriate for the research. During the period of this investigation, health reform evolved from a much-debated issue regarding whether it should be undertaken, to the initiation of the process and the impact on physicians as a group. This rapidly changing scenario, part of the external environment, has implications for the way the services are offered and the effect this has on the way professional practices operate in the health industry. The variety and intensity of these external changes and their impact on the service provider/owner manager of the service practice provided significant input for the research.

The objective of this chapter is to relate the findings described in chapters 5 and 6 to the wider context of marketing in small professional service enterprises and to services marketing in general. The contribution of this research is presented and recommendations for future research are suggested.

## **7.2 SUMMARY OF FINDINGS AND CONCLUSIONS**

### **7.2.1 Overview of Findings**

The analysis of the quantitative survey of physicians in Puerto Rico reported in chapter 5, showed most of the physicians surveyed claimed to spend most of their time in private practices as solo practitioners with ten employees or fewer. The cases studied (chapter 6) confirm that physicians in solo practice in Puerto Rico are a group most relevant to study as a way of



learning more about the marketing of professional services in general and in the smaller enterprises in particular.

The analysis of the quantitative survey (section 5.2) revealed that there appears to be a shift, compared to the literature, in terms of physicians' favourable opinions towards marketing in general, the understanding of what marketing is and the role of marketing in the medical profession. The indication is that this shift is likely to continue, increasing the understanding of marketing and presumably leading to more use of the various marketing techniques currently used only in a limited way.

The analysis of the quantitative survey further revealed that although physicians agreed with the use of marketing, and claimed to have a good understanding of it, most did not adopt traditional marketing techniques. The use of marketing techniques amongst physicians in Puerto Rico is limited as they are not interested in undertaking many marketing activities but prefer to emphasise managing service quality effectively and maintaining a focus on the personal and unique nature of the physician-patient relationship. Thus, physicians' focus is on long-term relationship building (vis-a-vis a short term transaction oriented goal). All of this is in strong agreement with the literature regarding the relationship marketing concept of services (Berry, 1983, 1995; Berry and Parasuraman, 1991; Grönroos, 1989, 1990a, 1990b, 1995; Gummesson, 1981, 1987, 1990; Jackson, 1985; and Levitt, 1986). This high degree of agreement with the concept of relationship marketing suggests that it is most important for professional service providers, such as physicians, particularly when the service is conducted in the setting of the smaller firm.

The analysis of the qualitative survey reported in chapter 6 examined the "how" and "why" questions of the physicians' level of agreement with marketing, and how marketing actions are

decided upon and implemented. The physicians studied show that this group of professional service providers understand and practice a market orientation as they value and place special emphasis on the physician/patient relationship. The positive physician/patient relationship was unanimously identified by the physicians studied as a major explanation of how patients learn about the practice and return. Physicians differ in how they understand it is best to enhance the physician/patient relationship and this explains what actions they do (or fail to do) and how these are carried out. Many of the physicians, nevertheless, do not see this as marketing, possibly because of their limited understanding of what it involves.

The cases studied suggest the orientation of the physician as to how best to enhance the physician/patient relationship determines what he/she does to market and manage the practice. Other variables, such as the region where they operate, the type of physician classification (primary/secondary), among others, do not appear to have a major impact on why marketing actions are undertaken (or not).

Physicians that understand that changes in the marketplace (external environment) adversely affect the physician/patient relationship act in a manner consistent with protecting this relationship from the outside "*commercialisation*" pressure. Physicians that understand change in the marketplace as positively impacting at the physician/patient relationship act in a manner consistent with embracing such changes. Both groups of physicians agreed on the importance of attaining and maintaining the best possible physician/patient relationship. Both groups also understand that in their solo practice they have the control to act according to what they understand enhances the physician/patient relationship. Thus, those physicians that believe the best way to enhance the physician/patient relationship is to resist external "*commercialisation*" pressures, act accordingly. Likewise, those physicians that view external changes as positive, embrace them as a way of enhancing the physician/patient relationship.

The findings of this research in the setting of the small professional service practice, and the motivations of the service provider, have a high impact on the operation of the service firm throughout the life cycle of the service provider. This does not support the model utilised as the general framework for the research, which proposes that the owner's goals and motivations (as part of the internal environment of the firm) have a higher impact in the early stages of the firm's development. As explained, the findings show the owner's goals and motivations have a significant impact throughout the life cycle of the firm. In essence his/her motivations throughout his/her personal life cycle equate to the firm's goals throughout its business life cycle.

#### **7.2.2 Overview of conclusions**

The analysis of the quantitative and qualitative surveys points to the intricate relationship between the personal characteristics, motives (internal environment) and a variety of influences impacting on the practice owner/manager/service provider (external environment) and how these in turn impact on the small solo practice itself. The most relevant factors that influence the service provider and thus the service practice are presented in the sections that follow, divided into conclusions regarding the Model for Marketing in Small Professional Service Firms (section 7.2.2.1), external factors such as competition and changes in the industry that impact on the practice (section 7.2.2.2), the cultural setting of where the service practice operates has an important role in understanding why the service provider places a marketing emphasis in one particular aspect of the practice versus other aspects (section 7.2.2.3), factors regarding the internal environment (section 7.2.2.4), the characteristics of the service delivery mechanisms available to the service provider (section 7.2.2.5), the process of adoption of marketing techniques (section 7.2.2.6). All of these characteristics force the service provider to focus on the one type of marketing activity that produces the best results (section 7.2.2.7).

The overall conclusion of the research, thus, is that the elements impacting on what marketing activities are done, how they are undertaken and why they are utilised at a particular point by small professional service providers are constantly in different stages of evolution, making marketing practices contingent on both the external and internal environment of the practice. This conclusion suggests the need for research in small firm marketing to utilize a contingency approach to understand its marketing decision making and behaviour, as advanced by Siu and Kirby 1998.

#### **7.2.2.1 Conclusions vis-a-vis the Model for Marketing in Small Professional Service Firms**

The Model for Marketing in Small Professional Service Firms (figure 2.3) utilised as the general framework for the research shows that the initial role of the owner/manager changes over time. Namely, the personal goals, attitudes towards marketing the professional service practice, and the use of personal contacts, have a higher impact on the firm as it initiates operations and diminishes over time as the firm grows. The external environment, on the other hand, has an increasing impact on the marketing activities of the firm as it grows. Changes in industry practices (including those resultant from an increase or decrease of regulations) and competitive pressures, among other external factors, increasingly require the enterprise to adopt advanced marketing activities in order to survive and grow in the changed competitive environment.

The findings of the research do not support the construct of the model as both, the quantitative analysis (chapter 5) and the qualitative analysis (chapter 6) suggest factors in the external as well as in the internal environment have an impact throughout the life cycle of the firm.

### 7.2.2.2 Conclusions regarding the External Environment

Factors external to the service provider, such as competition and changes in the industry, were predicted to impact the various professions (Kotler and Bloom, 1984, section 2.5). Nelson and Goldstein, 1989, p. 87 (section 2.6) specifically commented on the marketing issue in the decade on the 1990s in healthcare because the industry *"is dealing with increasingly sophisticated consumers, employees, government agencies and other buyers of health services"*. The physicians studied revealed these changes and the findings suggest such external factors impact on the motivations of the service provider. The analysis of the physicians studied provides examples of this: case 8, two physicians in mid career, as a result of the changes in the health reform process have asked their accountant to evaluate the practice in terms of its effectiveness as they envision selling it to a multinational healthcare company and then working for the company. Case 6, the youngest of the physicians with the youngest medical practice, is implementing controls, and performance standards and has an outside entity auditing his performance as a mechanism to compete effectively in the changing arena of health care within a managed care system. Cases 3 and 7 appear not to worry too much about the effect the changes in the health care system might have on their practice as they are close to retirement.

Notwithstanding that changes in the external environment, including competition and reform of the industry as a whole, impact on the motivations of the service providers in small firms, the manner they react to these appears to differ from that of the larger enterprises. All of the cases studied reported a mostly informal decision-making, implementing and monitoring process (section 6.2.5). This is in contrast to the traditional marketing model utilized by larger companies (formal long term planning proactive perspective in planning, and aggressive marketing objectives and strategies) (Brooksbank et al. 1992). This study supports Carson's (1990) belief that small business owners adapt marketing to their particular requirements and

have a marketing style inherently informal in structure, evaluation and implementation. This study is also in agreement with Hogarth-Scott et al. (1996) whose research reveals sophisticated formal procedures as inappropriate for small firms.

### 7.2.2.3 The Setting of the Service Practice

The findings of this research differ markedly from the notions advanced by Zeithaml and Bitner (1996, pp. 31-32), namely:

*"While the requirement for customer focus may seem obvious to a marketing student or practitioner, the reality is that many organizations- private, public and even non-profit- have historically viewed the customer as a distant and sometimes even bothersome necessity. To these companies ... focus on the customer brings with it a major culture change."*

*"Customer focus is also anathema to many professional services organizations medicine, law, accounting, even higher education. To these and other professions, there seems to be a conflict between technical excellence and customer-perceived excellence. Lawyers, for example, sometime see customer focus as a paradox: customers, they believe, are not knowledgeable enough to know what they need. What legal clients want, they contend, is to receive the least costly, least constraining advice- the opposite in many cases of what the experts know they need. Physicians and dentists sometimes offer a credible argument about the difficulty of simultaneously providing high technical quality and customer satisfaction: courses of treatment needed to eliminate disease are often painful and uncomfortable."*

Two major reasons appear to explain the difference: the size of the practice and the cultural context of the research. Zeithaml and Bitner (1996) refer to service firms, including professional service firms, in general terms- without attempting to qualify their statement in terms of the size of the enterprise. This research focuses on the small service firm, specifically solo physicians' practices, where the service provider is also the owner, the manager and marketer. For this service provider, developing a consumer focus is the result of narrowing the options he/she can manage in an overburdened work environment to the one key aspect that he/she believes attracts and retains patients (section 6.2.4). The setting of the service practice (small solo practice vis-a-vis larger size service practices) appears to be a significant factor in

the number and type of marketing activities undertaken, as well as how important the service provider(s) believe such activity(ies) to be.

The other major reason that appears to explain the difference in the findings of this research with the conclusions of Zeithaml and Bitner (1996) is the cultural aspect. Zeithaml and Bitner's observation is based on research and the evaluation of service providers and customers within the North America setting. The particular cultural aspects within which service providers operate in that particular region do not necessarily represent the cultural values in other parts of the world. The present research was not conducted in North America, it was conducted in a Commonwealth of the United States- physically located in the Caribbean and historically linked with Latin America. The cultural setting where this research is conducted may thus account for the marked difference in the type of findings presented in this thesis vis-a-vis the conclusions of Zeithaml and Bitner (1996).

A specific example of this cultural difference has to do with the emphasis the cases studied (chapter 6) placed on the aspect of time. Physicians' interviewed repeatedly highlighted the importance given to investing time with the patient in order to better diagnose, to better listen to the patient, to allow for the physician/patient relationship to develop. All service providers studied believe the relationship to be one of the most important aspects of attracting and retaining patients. The cultural differences in terms of time and relationships presented in the literature (Hall 1959, 1960, Hall and Hall 1987, Kaufman and Lane 1990, and Hawkins, Best and Coney 1995) are best illustrated by Hawkins et al. (1995, pp. 48-49):

*"...Americans and Canadians tend to view time as inescapable, linear, and fixed in nature...We have a strong orientation toward the present and the short-term. This is known as monochronic view of time. Other cultures have different time perspectives. Latin Americans tend to view time as being less discrete and less subject to scheduling...People and relationships take priority over schedules...They have an orientation towards the present and the past. This is known as a polychronic time perspective...[while an individual in a] monochronic culture...[is]... committed to the job or*

*task...[and] ...accustomed to short-term relationships...[an individual in a] polychronic culture...[is] committed to people and relationships...[and]...prefer(s) long-term relationships."*

The cultural dimension has been recently receiving attention as an explanation of why *"traditional Western marketing tenets may not be fully applicable to non-Western countries"* (Siu and Kirby 1996, p. 119). In their research on marketing practices in small firms in Hong Kong (Siu and Kirby 1996, p. 119) found that *"socio-cultural influences may need to be considered when attempting to understand the marketing practices of small firms in Eastern countries and developing and transitional economies."* This research found that the issue of culture may be relevant within Western countries, suggesting that in professional services marketing, a slight cultural variation may result in major differences in service provider behaviour.

The contribution advanced with this analysis is that the cultural dimension where the practice takes place is an important aspect of the external environment as it provides a particular meaning, a particular influence on the service provider and on the customer. The possible cultural peculiarities, therefore, need to be understood and taken into account to understand what is important to the service provider and to the customer and how this impacts on the way the service is provided, the service encounter itself, and the resultant evaluation of the satisfaction with the service.

#### **7.2.2.4 Factors regarding the Internal Environment**

Various aspects of the internal environment of the firms according to the findings, warrant particular mention. The research was particularly insightful in showing that the personal goals of the service provider change over time, as a result of his/her own change in the personal life cycle as well as the evolution of the service practice and the changing external environment



(section 6.4). All of this, in turn, has an impact in the type of service firm he/she desires to operate. The choice of a solo professional service practice has various peculiarities that impact on the internal environment of the firm and are discussed in section 7.2.2.5). The findings of the research also points out to the change of attitude towards marketing by service providers, however, the adoption of marketing techniques at this time is limited, thus pointing out to a process of adoption of marketing by professional service providers presented in section 7.2.2.6. Finally, the impact of both internal and external factors on the solo practice requires the service provider to focus on the one activity that, in his/her view, produces the best results for attracting and retaining clients (section 7.2.2.7).

#### **7.2.2.5 Characteristics of the Service Delivery Mechanism**

The characteristics of the particular options to deliver a service influence and motivate the service provider's preference for choosing one delivery mechanism over another. The physicians studied choose to work in solo practice as they are motivated by the opportunity this type of practice provides for establishing, what they consider to be, an appropriate physician/patient relationship (section 6.3). The physicians interviewed believe the controls they need to provide the best care are attained in solo practice. This is explained by Shollhammer and Kurilof, 1979 (section 2.7) as some of the attributes of small businesses: the independence the owner/manager has and how that impacts on the management style, namely lack of sharing of decision making. The biggest obstacle for physicians favouring the change to managed care at this time is precisely their concern with losing control to decide what is best for the patient. This point can not be emphasised enough for physicians in Puerto Rico and the United States. According to Johnson (1998, p. 17) physicians in private practice understand "...that (their) independence is gone ... Doctors concede money is a motive but insist their greatest concern is regaining control over medical decisions. Many doctors accuse HMOs

[Health Maintenance Organisations] of ruining the doctor-patient relationship by overruling them on treatment, leaving patients with less-than-optimum care." This is further illustrated by Kotler (2000, p. 444) as he explains that the pressure to increase the quantity of service has an adverse impact on the quality as "Doctors working with some HMOs have moved toward handling more patients and giving less time to each patient."

The study is in agreement with the overall perspective of marketing as being a customer oriented activity for businesses (section 2.3) and suggests the relationship marketing concept (section 2.4 and 2.4.2) as particularly appropriate for the small firm operating in the service sector. This is explained in the literature on small business marketing (section 2.7) by Roger (1990) who argues that since small firms concentrate operations locally they deal directly with the final consumer, having greater control over the selling process. The literature on marketing of service firms (section 2.4) explains this because of the involvement of the customer in the delivery process as a "co-producer" (Edvardsson and Mattson, 1993) and the resultant interaction between the customer and the service provider (Edvardsson et al. 1989).

Motivations, opinions, beliefs may change over time as service providers, in the process of adopting change, impact on other service providers. The findings of this research in terms of the process of adopting marketing techniques for the practice and the impact it has on other service providers is discussed in section 7.2.2.6.

#### **7.2.2.6 The Process of the Service Provider Adopting the use of Marketing Techniques**

The statistical survey formulated forty one specific statements drawn from the literature and the physicians indicated their agreement, disagreement or neutrality with each. The analysis vis-a-vis the literature, chapter 5, revealed there appears to be a shift in terms of physicians' opinions

towards marketing in general, the understanding of what marketing is and the role of marketing in the medical profession. The indication is that this shift is likely to continue, increasing the understanding of marketing and presumably leading to more use of the various marketing techniques currently used only in a limited way. The cases examined, chapter 6, when viewed within the context of the results of the statistical survey (chapter 5) suggest the diffusion adoption process model (Rogers, 1983, Mahajan et al., 1990, Kotler 1991, and Hawkins et al. 1995) as a way to explain the adoption of marketing techniques by the service providers. The diffusion process (see appendix 24) is defined by Hawkins et al. (1995, p. 174) as "the manner in which innovations spread throughout a market" and is used to explain the way consumers obtain, over time, an innovative product or service. The adoption process (Rogers, 1983) distinguishes amongst consumers based on adoption categories- the first being the "innovators" followed by the "early adopters", "early majority", "late majority" and "laggards". Although the diffusion process/adoption process has been used mostly to describe the adoption of innovation by consumers, this research suggests that it may apply to professional service providers and their behaviour of adopting marketing techniques for their practice.

This is supported by the analysis of several cases (chapter 6). Table 7.1 below illustrates the adoption categories (Rogers, 1983) and how the physicians studied could be categorized, based on their use, lack of use of marketing techniques for their practices. Case 6, for example, is the youngest of the physicians studied and is very aggressive in terms of his use of marketing techniques (ie. segmentation strategies, use of advertisements to attract patients that can decide on their own which physician to visit, negotiations with group practices and others to get their referrals of the patients they have "captured"). He is a good example of the "innovator" category- the first small percentage of physicians adopting the use of marketing techniques for their practice. Case 1 is a good example of the "early adopter" category by using advertising for his practice because other physicians with the same specialty in the same geographical

region have done so, admitting he will not initiate certain marketing actions, but will follow such moves if undertaken by other colleagues. The reluctant possibility faced by case 2 of the frequent use of marketing techniques shows the type of peer pressure the adoption process, once underway, has on others. The Physician Marketing System (section 6.3) makes reference to this as physicians catalogued in group B are influenced by what their peers in that group do.

Table 7.1: Physicians' Adoption of Marketing Techniques

<u>Adoption Categories</u> <u>(Rogers, 1983)</u>	<u>Cases</u>
innovator	6, 3
early adopter	1, 5
early majority	7
late majority	2, 8
laggards	4

The characteristics of the physicians studied resemble the characteristics of individuals as they adopt, over time, innovations in the marketplace. The use of marketing techniques for physicians, and indeed for most professional service providers, was practically non existent over a decade ago- given the fact that the respective professional associations forbade their use by declaring them unethical (Milliman and Fugate, 1993). The elimination of the legal restrictions that banned the use of marketing practices, including advertising, for the professions, together with the increasing competitive marketplace, has made the use of such techniques a reality (Berry and Parasuraman, 1993). The use marketing techniques, as the research has shown, is not a common practice yet among doctors in Puerto Rico, though, compared to the literature, a shift appears to have occurred in terms of the change of attitudes towards their use. In the case of the use of marketing techniques by physicians, it can be argued that physicians as a group are going through a slow adoption rate, with the perspective that the techniques will continue to be adopted by more physicians over time. The marketing techniques that are adopted, based on the findings (section 6.3) are those that, in the physician's view,

enhance the physicians/patient relationship. These might include internal marketing (section 2.4.5) to better incorporate the staff at the practice into the marketing process in a manner consistent with enhancing the relationship with the patient.

#### **7.2.2.7 The Service Provider's Need to Focus**

The literature on the consumer perspective of determinants of patient satisfaction presents a wide variety of variables used to measure the satisfaction level of consumers (section 2.6). The variables used include communication, measurement of patients' attitudes towards the system, physician and medical care received (Hulka et al. 1975); retention of information conveyed from physician to patient (Bertakis, 1977 and Ley, 1983); practice premises, receptionists, appointment system (Kaim-Caudle and Marsh, 1975); and satisfaction with outcome and continuity of care (Woolley et al., 1978). The aspect of the physician/patient relationship is one of many factors included in the patient satisfaction research noted in the literature (Feletti et al. 1986, and Wolf et al. 1978).

This research analysed the perspective of the service provider and its conclusions differ from the literature that notes the relationship aspect as one of several factors in consumer satisfaction. This research suggests that the relationship is the core factor that mostly impacts on the decision of the physician on what to do to satisfy consumers in the long run. This is in agreement with Brown and Swartz (1989) who measured service quality on a sample of patients from 12 physicians and determined that the most important factor in determining patient satisfaction is the interactions with the physicians.

According to the research, the reason for the service provider to place emphasis on only one key aspect of the service encounter (in the case of this research the physician/patient relationship) is

possibly the result of the fact that the service provider, as owner, manager and provider of the service in a small professional practice, has practically all of the weight of the practice placed on him/her, and thus needs to focus on a key aspect of the practice, rather than diluting the efforts in many other marketing activities. This forces a reduction of actions to be undertaken, a prioritising of which one type of action is best, in the opinion of the service provider, for the effectiveness of the practice.

### 7.3 IMPLICATIONS FOR THEORY

The findings of this research, both corroborate and refute some of the literature on marketing for small firm and professional services.

The findings fully corroborate the five attributes of small business advanced by Schollhammer and Kuriolof (1979), namely: 1- scope of operations (serving predominantly local/regional markets), 2- scale of operations (limited share of a given market), 3- ownership (equity owned by one or few people), 4- independence (not part of another enterprise, owner/manager has ultimate authority and control), and 5- management style (personalized, no general sharing of decision making). On the aspect of personalised management style, the findings corroborate Carson's (1985) description of a management style ...“without pre-planning or forethought...” (p. 7). More recently Geursen and Conduit (2000, p. 5) have concluded “...that the management function in the small and in the entrepreneurial firm is centralised and simple. It achieves effectiveness across the firm through the central pivotal position of the manager/entrepreneur”.

The research also corroborates the assertion by the Piercy and Morgan (1989a, 1989b) that external environmental factors produce tremendous pressure for professional service firms and

thus need to be considered to fully understand the environment in which firms operate. The findings, therefore also corroborates Davidsson and Wiklund (1999) who argue about the importance of taking environment influences into consideration, particularly in studies of small enterprises.

The findings of the research are in agreement with the notions advanced by Carson (1985) and Davis et al. (1985) regarding the impact that lack of resources have on small firms. Limited resources, including time “may contribute to limited marketing activity relative to large companies and large competitors” (Carson 1985, p. 9). Carson 1990 (p. 190) further explains that “...time consuming formal marketing planning will be deemed unnecessary (by the owner/manager that is enjoying) sales and profits growth without actually “PLANNING” any marketing activity...” more so in situations, as those encountered in this research, where growth is not necessarily the main motivation of the owner-manager. Fuller (1994), which expanded to Carson’s 1990 research and Model, further explains that “limitations of expenditure relate to resources and are described in terms of time and money devoted to marketing” (p.38). The owner-manager’s lack of time has as an implication the need to focus on few activities that he/she understand are important for the firm. Curran et al. (1993, p. 24), for example, comment that “...as the earlier analysis and previous research indicates, demands on owner-manager’s time are very substantial making extensive networking activity unlikely”. Similarly Geursen and Conduit (2000) have found time constraints require owner-managers of small firms to focus on cash flow management.

The area where the professional service providers in this research focused was the physician/patient relationship. This, as previously explained (sections 6.3, 7.2, 7.2.2.7), fully corroborates the literature on relationship marketing. The findings further support that the relationship marketing concept in small professional service firms is core to attracting and

retaining clients by placing considerable importance on the service encounter, where the services provider/client relationship develops and grows.

The literature (section 2.8.5) accentuated that in essence the owner's goals equate to the business goals at the early stages of the firm (Churchill and Lewis, 1983; Gibb and Davies 1990; Scott and Bruce, 1987) but, as the company evolves throughout its life cycle, the need for growth dictates the company's goals. For this reason the general framework for the research incorporated into the Carson model (1985, 1990, 1993) (figure 2.2) the internal environment, particularly as it related to the owner's goals, as having a higher impact in the early stages of the firm. The findings from the statistical survey (section 5.2.4) and the cases (section 6.4) however, did not support this construct of the model.

In this research the owner's goals appears to always equate to business goals, perhaps because solo practices were studied. Owners of such firms choose to be in solo practice to exercise be able to run the practice as they understand best (section 7.2.2.5). Thus, in the setting of small professional service firms, where the service provider/owner-manager has to continue to be involved in the service delivery process (as well as in managing and owning the firm) the personal life cycle of the owner/manager "dictates" the life cycle of the business. As explained earlier in this section Geursen and Conduit (2000, p.5) refer to this as "... the Central pivotal position of the manager/entrepreneur..."

Another finding that refutes the literature upon which the model (figure 2.3) was developed has to do with the use of word of mouth and referrals. The literature (Carson 1985, 1990, 1993) specifically situated these two elements as important in the early stage of the firm. The findings show word of mouth and referrals (including those related to the personal contact network) as important throughout the life cycle of the firm. A possible explanation for this is that



“...service consumers generally rely more on word of mouth rather than advertising” (Kotler 2000, p. 436).

The interaction between external and internal factors, according to the findings, is more crucial than what some of the limited literature suggests (Rea et al. 1999, and Candler and Hanks, 1994) Carson (1985, p. 12) refers to the “pressure for more sales [to survive via growth]...can bring about a fundamental change in attitude towards marketing in the owner/manager of the small firm”. This research also shows “pressure” from the external environment (in this case to adopt/not adopt marketing). Thus the commonality of the findings with Carson’s is that small firms are impacted by outside pressures (which may differ from region to region, particular industry, regulatory environment, or competitive environment, for example). These external pressures interact with owner manager and in the process impact on his/her attitudes (either changing them or reaffirming them).

Possible explanations for the findings (vis-a-vis the literature) is that the emphasis of the models is based on growth. For that reason some of the literature also refers to them as “growth models” or “stage/growth models” (section 2.8.1). Given the growth motive, as Carson developed his initial model (1985, p. 12) he stated that “...the small firm must continue to expand...and the soundest basis for expansion is a consistent growth of sales revenue”. The findings (section 6.4) indicate growth might be motivation at a particular moment in the personal life cycle of the service provider, but is not necessarily the main motive throughout the life cycle of the owner/manager, therefore growth is not the main emphasis of the practice throughout the life cycle of the firm. The main reasons for the findings (vis-a-vis the literature) has to do with the nature of the models. Other models (including Carson’s), although about small firms, are not specifically related to three characteristics:

- 1- Professional services- where the service provider tends to equate to the service itself. One of the four basic differences between services and goods is the aspect of inseparability of the services provider from the service (Kotler 1994, and 2000, Lovelock 1991, section 2.4).
- 2- Solo practices- where owner's goals equal business goals throughout the life cycle of the firm.
- 3- The importance of the attitudes of the owner-manager/service provider- given the combinations of characteristics one (professional services) and two (solo practices).

This is further reviewed in section 7.5.

#### **7.4 IMPLICATIONS FOR PRACTICE**

The objective of the research included advancing the implications for practice of the findings.

This section provides the implications for practice as a result of the findings from the research.

Providers of consultancy, training and other services for small professional service firms should be aware of the characteristics peculiar to

- 1- service firms (vis-a-vis products)
- 2- small firms (vis-a-vis larger enterprises)
- 3- industry specific characteristics (ie. health care in this case) with the resultant need to understand the changing external environment of the industry and its impact on small professional service firms

The time constraints of the service providers once they operate their practices, together with the fact that they are not trained in business, suggests that the best time to receive “formal” training about marketing their practices is while in their last years in medical training. The case that is doing more proactive marketing (case 6) learned about marketing and how to use it for his practice while in medical school from one of his medical professors.

The Medical Association could initiate training and consultancy services specifically catered for physicians. This could be done as:

- 1- their regular programme for continuing education to physicians
- 2- as part of the annual convention of the Medical Association where they usually have a training track
- 3- a way to enhance the staff of the physicians- given the part-time marketer concept, similar training for other personnel from the physician’s practice could be provided.

Given the physician’s “misunderstanding” about the term marketing (thus their “apprehension” to use marketing techniques, and considering they are in agreement with being patient centred and value the physician/patient relationship) training about marketing should be positioned as the best way to achieve effective physician/patient relationships. To achieve this, it is appropriate to reduce (or eliminate) all examples, language, etc. that can be construed to mean *“commercialization.”*

Since physicians do not hire marketing expertise, but do hire accounting services, the accountancy firms (which have been diversifying by providing advising services) could consider providing some type of marketing advice. This would build on the relationship already in place between the two parties.

Private health insurers that have obtained the management contracts to administer the health reform programme in various geographical areas (given the changes in the market place- chapter 4) could undertake training and consultancy to physicians as a way to better the operation of the medical practices in the regions covered by the insurers. Likewise, hospitals could also provide training and consultancy to enhance the relationships they have (or want to establish) with the service providers that refer patients to them and that decide in which hospital(s) they will perform operations and other medical procedures for their patients. The Health Department (government entity) could serve as a facilitator for such initiatives.

Banks and other financing entities could hold seminars, and provide advise and practical booklets for the service providers as a mean to help them be better prepared for the task of running the practice effectively in a changing competitive environment. The financing institutions could even require the owner/manager to take part in those types of training initiatives as a pre-requisite for loan disbursements.

## **7.5 CONTRIBUTION**

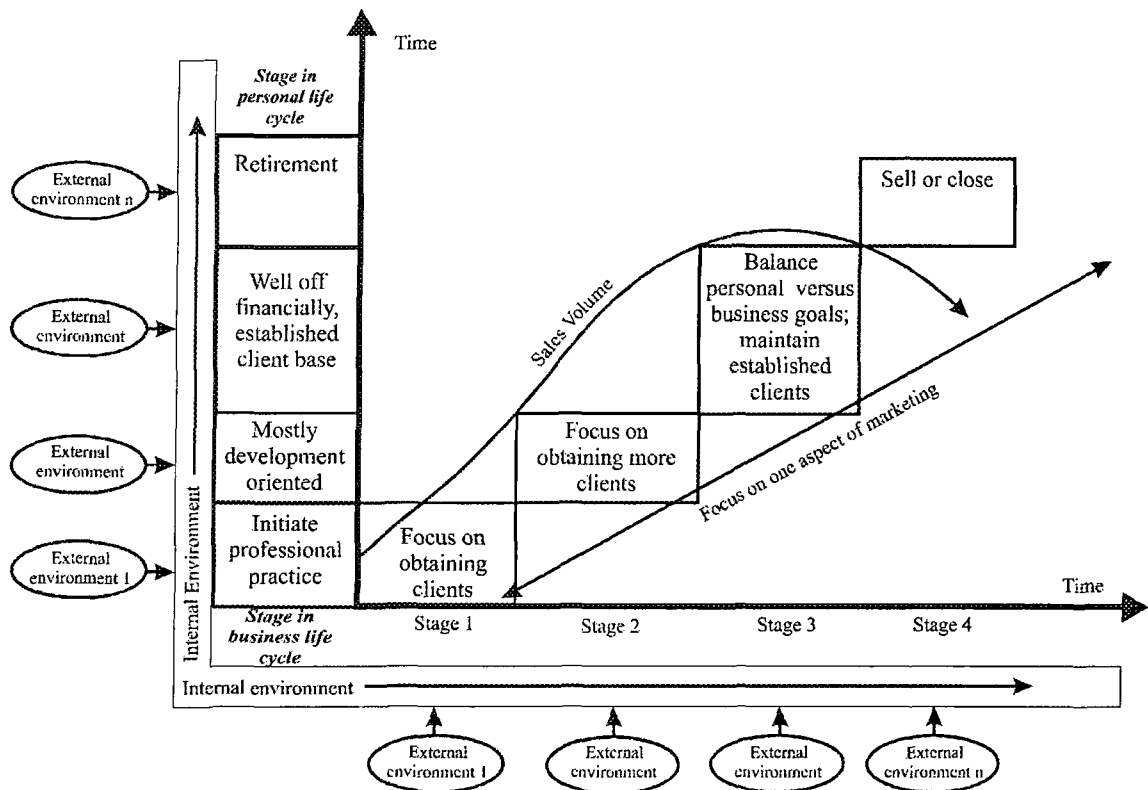
The literature review (chapter 2) examines the evolution of marketing from a discipline originally focused mostly on products and moving into other areas, including services marketing. The difference in the characteristics of services (vis-a-vis physical goods) requires a different way to market them and has evolved into an area of separate study (section 2.4). Likewise, small firms exhibit different characteristics from larger enterprises, resulting in differences in how marketing is undertaken and thus has also resulted in an area that merits separate study, albeit there is an absence of appropriate small business marketing theory (section 2.7). This research points to the possibility that the characteristics and behaviour of small professional service firms (particularly with solo practitioners) might make them a

separate sub set, a different segment within the small firms sector. This may explain the differences in how they go about conducting marketing. It can be argued, then, that the characteristics solo professional service firms exhibit (which are different, to a large extent from small firms in general), has implications for both theory and practice (sections 7.3 and 7.4).

The findings of this research, as explained in section 7.3, corroborates much of the literature on small firm marketing, but is not identical. Further, the research suggests that the marketing of solo professional services, indeed all of their management, needs to be placed within the context of external factors, such as the region in which they operate, the particulars of the industry, and the regulatory and competitive environment. Similarly, the research points to the importance of the personal life cycle of the owner/manager throughout the life cycle of the professional service practice and the resultant impact it has in regards to the internal environment as well as in dealing with the potential impacts of the changing external environment in which the practice operates. Thus, as previously mentioned (section 7.2.2), the overall conclusion of this research is the need for research in small firm marketing to utilise a contingency approach to understand its marketing decision making and behaviour.

Given the findings (section 7.2.1) and conclusions (section 7.2.2) of the research, a Model for Marketing Solo Professional Service Firms (figure 7.1) is proposed, utilizing the life cycle concept. According to the research, the life cycle model is appropriate to describe the behaviour and development, over time, of firms, in this case small professional service firms. As figure 7.1 shows, various components are included in the proposed Model for Marketing Solo Professional Service Firms, namely the external environment, the internal environment, the personal life cycle of the practitioner, and the business life cycle.

Figure 7.1 Model for Marketing Solo Professional Service Firms

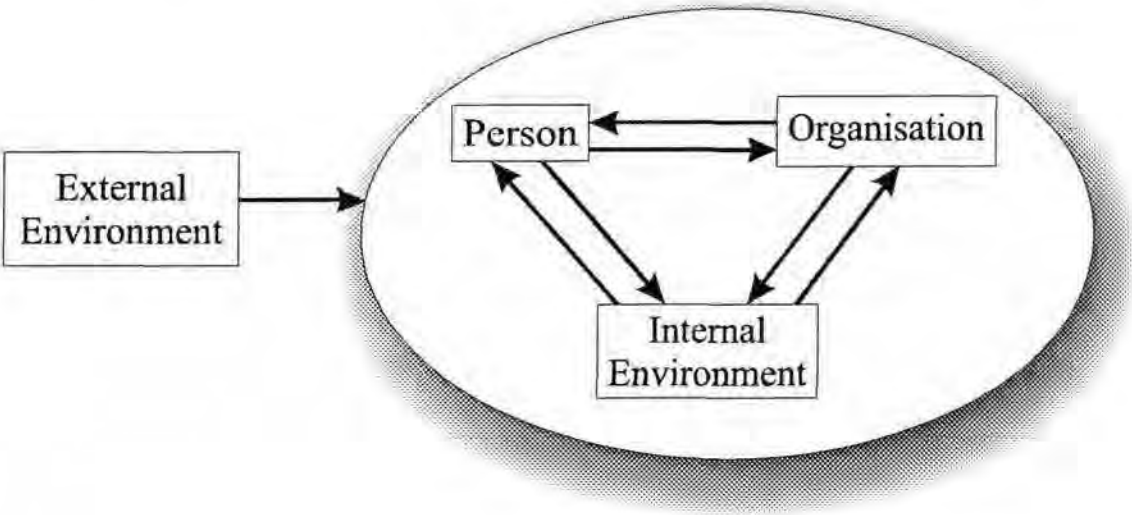


The external environment, which includes the particular industry and region where the practice operates, as well as regulatory environment and competition, changes over time (hence the codifications 1 to n) and impacts on both the service provider over his/her personal life cycle and the business over its various stages. The internal environment, under the “control” of the service provider/owner-manager, also evolves over time. The model depicts the relation between the changes, over time, in the personal life cycle of the service provider/owner-manager and the evolution of the stages in the business life cycle of the practice. Sales volume grows (business stages 1, 2 and 3) and the growth rate is then reduced (business stage 3) as the service provider/owner-manager’s personal life cycle demands a balance between his/her personal and business goals. This leads to a decline in sales volume (business stage 4) as the service provider/owner-manager purposively slows down his/her work pace as plans for retirement are initiated, the practice being either sold or closed eventually. Throughout this personal life

cycle/business life cycle process, given the lack of resources, in particular time, and the particular characteristic of the solo professional service practice, there is need to focus on one aspect of marketing for the practice. That one aspect of marketing (the physician/patient relationship in this research) may change over time given the changes in both the external and the internal environment, as well as the changes in the personal life cycle of the service provider/owner-manager and the stages of the business. However, according to the findings, there is at any one time a specific marketing focus.

The model incorporates the context in which the firm operates, namely the external and the internal environments, as well as the interactions of the service provider/owner-manager with these and the resultant impact such interactions may have in the marketing of small firms. These interactions are further illustrated in figure 7.2 below.

Figure 7.2: Interactions of Components of the Model for Marketing Solo Professional Service Firms



As figure 7.2 illustrates the four components of the model, namely the person (service provider/owner-manager), the organisation (the small firm), and the internal, and external environments, are in continuous interaction. The external environment is a dynamic force

continuously impacting on the organisation and the service provider/owner-manager, thus requiring him/her to ponder alternative courses of action. Even if the individual and/or the organisation decide not to change their modus operandi (including not changing how marketing is undertaken) it can be argued such a decision is taken as the result of this process of interaction, which includes pressures from the changing external environment.

## **7.6 LIMITATIONS OF THE RESEARCH**

It is recognised that the research has limitations related to the nature of the area under study, the methodology, and lack of measurement of additional variables.

The rapid nature of change for the health industry in Puerto Rico provided a rich variety of inputs for evaluating and analysing the results of the research. The limitation of this, however, was the resultant "turmoil" that impacted on the subjects' attitudes and perceptions as the fieldwork was undertaken. This situation made studying the physicians' attitudes equivalent to going after a moving target and could have resulted in a limitation on the analysis of the results of the research.

The research focused entirely on the service provider. The analysis of the statistical survey and the cases, therefore, is entirely based on the perspective of the provider and lacks the input from the customer. This is always a limitation, more so when the focus of the study is marketing. Because of the issue of confidentiality the methodology did not provide a good link between the physicians' surveyed (quantitative research) and the cases studied (qualitative research). The trade off of allowing for physicians in the survey to remain anonymous (with the purpose of providing them with the freedom to express themselves fully) did not allow for the cases to be obtained necessarily from amongst those that participated in the survey. Had this been done,



the cases could have been selected to be representative of the physicians that answered the survey and that could have provided the opportunity to connect the findings of the quantitative research with those of the qualitative analysis.

The analysis does not evaluate the results the various actions of the service provider on the performance of the practice. Does the One to One Market Approach proposed in chapter 6 (figure 6.1) produce better results for the practice vis-a-vis the Multi-level Approach? This could have been evaluated from the perspective of the service provider and the perspective of the customer in order to allow for comparisons.

The limitations of this research, together with the findings and the contributions it presents, provide the basis for the recommended areas of future research that are included in the section that follows.

## **7.7 DIRECTION FOR FUTURE RESEARCH**

The growing changes in the health care environment in the area under study, such as the implementation of the health reform in all of Puerto Rico, appears to widen the differences between primary and secondary physicians- given the role of primary physicians as the gatekeepers of the health system. Furthermore, the increase in marketing actions, such as advertising by other physicians, points to a growing gap between the two "difference levels" explained in section 6.3 (figure 6.1). That is, the gap between how physicians believe such changes damage/enhance the physician/patient relationship and the gap among physicians in each group with regards to the level of damage (thus the need for a certain level of protection) or the level of enhancement (thus the need for a certain level of embracing) of the physician/patient relationship. It is recommended, therefore, that after the health reform is fully

operational, the possible growth in these difference levels and the implications this can have on the way physicians in Puerto Rico undertake marketing activities for their practices be further studied.

The continued effect of the changes in the external environment in the way in which service providers market their small professional practice needs to be studied over time. Thus, an area for future research is to conduct a longitudinal study in Puerto Rico.

This research has dealt with the perspective of the service provider. An area for further study is the perspective of the patient where the literature (Berry, 1995) points out that relationship marketing benefits the customer who ultimately desires "... continuity with the same provider, a proactive service attitude, and customized service delivery" (Berry, 1995 p. 237). Other professional service providers, such as accountants and lawyers in the same geographic region, could be studied in an effort to compare the results of such research to those presented here. Such research effort can provide data from other professions that will help establish if the findings of the current research are similar to, or different from, other professional service enterprises.

Future research should include the aspect of practice performance in order to measure the marketing actions undertaken by the service provider vis-a-vis the results of such actions and compare the relative benefits of such actions.

The cultural variable should be included in the analysis of future research to understand marketing actions within the context of where the service is provided. The aspect of culture needs to be included in future research as it appears to impact on the service provider, the customer and the relationship which develops from the service encounter(s). A

recommendation to further evaluate the possible effect of the cultural variable in the marketing process of small professional service firms is to replicate this study elsewhere. A way to operationalise the cultural variable is by conducting the research in several countries, each with a different pattern of cultural behaviour, utilizing Hofstede's (1991) value dimensions. This methodology has proven to be relevant in comparing the cultural context within small business in countries with different patterns of cultural behaviour (Rauch et al. 2000).

## **7.8 SUMMARY**

The literature survey the (chapter 2) identified the evolution of marketing from mostly the marketing of products to the marketing of services, and the basic characteristics that make services and products different. The marketing of services was further segmented to analyse the literature on the marketing of professional services in small practices to identify the areas to be studied and provide the theoretical context of the investigation. Most of the major studies on the subject were conducted after the elimination of the restrictions that banned the use of advertising and other marketing activities by the various professions. A series of statements originally utilised in those studies was selected to use in a survey with physicians in Puerto Rico- the area where the field work for this research was conducted.

The analysis of the quantitative survey (chapter 5) indicated a possible change of attitude of service providers towards marketing and its use for their professional practices a decade after the elimination on the restrictions on the use of advertising and other marketing activities. That phase of the research revealed physicians in agreement with the use of marketing, claiming to have a good understanding of it, but most of them were not adopting traditional marketing techniques- preferring to emphasise managing service quality effectively and maintaining a focus on the personal and unique nature of the physician/patient relationship.

The "why" and "how" questions were sought by the use of case studies. The analysis of the cases (chapter 6) reiterated the importance physicians in solo practice place on the physician/patient relationship and further explained why they unanimously placed it as a core element, perhaps the core element, of their practice: all the cases believe the physician/patient relationship to be one of the major reasons that patients are attracted, and return, to their practices. Most do not see this as marketing, nevertheless, as they understand marketing to be mostly advertising and selling and are most cautious not to "*commercialise*" their practice. The difference in behavior amongst physicians (some doing more aggressive marketing- including advertising vis-a-vis others not doing so) is explained by the differences in how they understand the physician/patient relationship is best enhanced. Physicians that understand that changes in the marketplace adversely affect the physician/patient relationship act in a manner consistent with protecting this relationship from the outside "*commercialisation*". Physicians that understand change in the marketplace as positively impacting on the physician/patient relationship act in a manner consistent with embracing such changes.

The question that surfaces, then, is why some physicians in solo practice would understand that changes in the marketplace would impact on the physician/patient relationship positively while other physicians in the same geographic region, with the same set of changes in the marketplace, would view them as adverse to the physician/patient relationship. The explanation, according to this research, lies in what motivates, what impacts on, the particular physicians (service providers). The variety of factors include personal characteristics of the service provider, external factors such as competition and changes in the industry that impact on the practice, the characteristics of the service delivery mechanisms available to the service provider (particularly operating as a small business) and the process of adoption of marketing techniques.

The analysis of the quantitative and qualitative surveys points to the intricate relationship between the personal characteristics, motives and a variety of influences impacting on the practice owner/manager/service provider and how these in turn impact on the small solo practice itself. The most relevant factors that influence the service provider and thus the service practice in the setting of the small practice, the way the practice is run, and the way the service is provided is decided by the service provider (in this research the physician) where personal motives, influences, and stage in the life cycle are, to a great extent, synonymous with those of the practice. The motivations, opinions, beliefs of the service provider may change over time, as he/she moves through the various personal life stages, and as other service providers adopt changes in the marketplace and this is reflected in the practice. According to this research, all of these characteristics force the service provider to focus on the one type of marketing activity that produces the best results. The cultural setting of where the service practice operates appears to have an important role in understanding why the service provider places a marketing emphasis in one particular aspect of the practice versus other aspects.

The contribution of this research is that it stresses the relationship marketing concept in small professional service firms as core to attracting and retaining clients by placing considerable importance on the service encounter, where the service provider/client relationship develops and grows. Other aspects of marketing and practice management play a role in the total marketing of a professional service practice. A possible contribution of this research, however, is the suggestion that the provider/client relationship is not just one of many variables but the central variable, the cornerstone upon which the other elements of marketing are placed. In essence, the argument does not intend to take anything away from the other aspects of marketing but to focus those other variables within the perspective of the service encounter (the service provider and the client)- where the relationship needs to be focused.

The main contribution is the proposed Model for Marketing Solo Professional Service Firms that depicts the relation between the changes, over time, in the personal life cycle of the service provider/owner-manager and the stages in the life cycle of the business practice. The model suggests that throughout there is a need to focus on one aspect of marketing for the practice, which may change over time, and that the elements determining the marketing activities at a particular time, how they are undertaken and why they are utilised, are constantly evolving. Thus the marketing practices of small professional firms appear to be contingent on both the external and internal environment of the practice.

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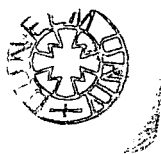
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